Special Report:

FIRST U.S. MISSION on MENTAL HEALTH to the U.S.S.R.

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U.S. DEPARTMENT of HEALTH, EDUCATION, and WELFARE
Public Health Service
Health Services and Mental Health Administration

National Institute of Mental Health
Chevy Chase, Maryland 20015
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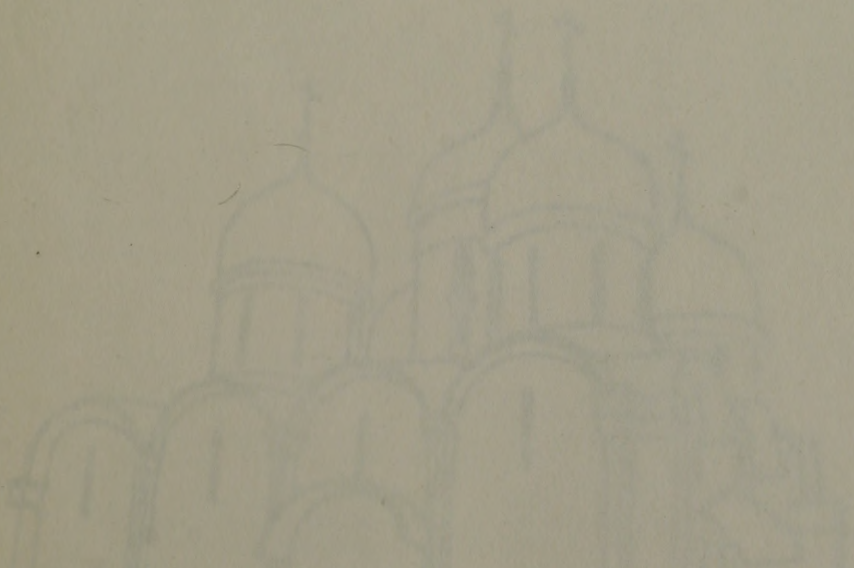

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Introduction

The first U.S. Mission on Mental Health to visit the U.S.S.R., in September 1967, was made up of seven men whose combined professional knowledge is representative of Western thought, action, planning and practice in the broad field of mental health. Individually, members of the U.S. Mission are specialists in one or more categories within this professional concern: the etiology of mental illness; the training and practice of mental health professionals; the legal and judicial responsibilities relating to the mentally ill; the organization, structure and delivery of mental health services in the United States.

Members of the delegation implement these concerns from a variety of viewpoints—those of Federal officials directing the National Institute of Mental Health; officials directing State mental health programs; the Chief Judge of a Federal Court of Appeals; the Medical Director of a professional organization; and a citizen advocate for mental health services. Of the seven, four were trained in medicine, specializing in psychiatry; one in law; one in political science; and one as a journalist whose reportorial observations of a need developed into a professional career as citizen activist in mental health.

As personal and professional colleagues of long standing, members of the delegation are accustomed to mutual discussion and debate. During the Russian visit, there were minor differences of opinion and emphasis among individuals, but the degree to which members of the mission agreed was striking. This report, therefore, although it represents a consensus is also to the best of the delegation's knowledge a thoughtful and accurate picture of mental health services in the Soviet Union.

The Soviet Union is a vast country which includes 15 Federated Socialist Republics, 20 autonomous republics, 8 autonomous regions, 111 provinces ("kray" and "oblast"), 10 national regions, 2,725 districts, 1,832 cities, and 39,698 rural groups.

In relationship to the geographic spread of the country, ours was not an extensive tour. We spent three weeks in Russia, visiting five cities—Moscow, Leningrad, Vinnitsa, Kiev, and Kalinovka—and touring more than twenty-five individual facilities. This sampling was intensive; and the members of the Mission are in agreement that the delegation experienced a substantial and representative exposure in securing a view of the organization and delivery of mental health services. It should be emphasized that the delegation did not undertake an extensive tour. There were areas that were not seen, facilities that were not visited, questions that were not resolved. At the same time, however, the delegation did see—and was shown—a great deal.

Prior to our arrival in Russia, the delegation had agreed to concentrate on organization, structure and delivery of services. Although we did secure additional information on mental health research and therapy, these areas of interest were peripheral to our main concerns. It is to be hoped, therefore, that future missions will be able to become informed in greater depth about Russian research investigations and therapeutic philosophies and practice.

Of primary relevance to the Mission's success was the courtesy and consideration afforded us by our Russian hosts, officially, professionally and personally, for which we are greatly indebted. And of transcendent importance is the fact that health services in the U.S.S.R. are systematically and comprehensively organized, so that once the delegation became informed about the organization, it was possible to observe any of its component parts or facilities and relate them to Soviet goals, objectives and performance in providing health services, in general, and mental health services, in particular, to the population.

Stanley F. Yolles, M.D.

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Chairman of the Delegation

PART I

Mental Health Services and Training in the Soviet Union

SUMMARY AND CONCLUSIONS

When the first United States Mission on Mental Health visited the Soviet Union in September, 1967, members of the delegation agreed that our primary purpose was to observe. However, in the course of our visits to the health facilities within the U.S.S.R., of our discussions with our Russian professional colleagues and the discussions within our own delegation, it was inevitable that we would compare and contrast the organization and delivery of health services in Russia with the provision of health care in the United States.

It became immediately evident that the health care systems in each nation reflect basic national attitudes defining the relationship between the individual and the State. Therefore, while health care in the United States is beginning to be considered as an individual "right", it is provided through a voluntary partnership between public and private resources within the United States. Americans will avail themselves of the opportunity for health care voluntarily, in relation to our social and cultural customs and our economic ability to finance health services for ourselves and our families.

In the Soviet Union, the provision of health care is a guarantee on the part of the State. However, it is more than a guarantee, for citizens of the U.S.S.R. are required to report to neighborhood polyclinics or factory medical units for regular physical examinations and prescribed treatment. Furthermore, once a Russian citizen is deemed to be in need of psychiatric care, he is registered and required by law to continue treatment for stated periods of time, dependent upon the diagnosis of his illness.

The differences in attitudes and requirements between the two health care "systems" therefore are fundamental. The stated national objectives of both countries in relation to provision of *mental* health services, however, are identical. The Russian health care system is designed to provide a continuity of care for all individuals; the national mental health program in the United States, since the adoption of the Community Mental Health Centers Act of 1963, is developing its own methodology, but the goal is the same.

Analyzed in terms of the objective to be achieved, the Soviets appear to have the advantage. As described in this report, the delivery of health care in the Soviet Union is a highly organized process which not only allows but requires the explicit formulation and directed implementation of precise goals. These include the geographic distribution of medical facilities; the assignment of specific doctor-patient ratios; the provision of salary scales and fringe benefits for medical personnel; and the planning and funding of the number and kinds of hospital beds and facilities.

Each of these components of the Russian health care system is developed to provide preventively-oriented, readily available and geographically accessible care. The continuously stated axiom of Soviet health officials is that health is a resource of the State, of equal importance to other more tangible resources. The Russians believe and operate on the belief that good health for all citizens must be maintained and promoted; and that ill health must be prevented when possible and diagnosed and treated when necessary. These are the operating premises of the Soviet medical establishment.

The delegation's report on the organization, planning and funding of Soviet health services in the following chapter outlines the procedures by which the Russians have developed medical facilities assigned on a geographic basis to meet the health needs of the population resident in a given "catchment area". It also points out the extent—surprising to our delegation—to which the actual implementation of national policy is delegated to subordinate governmental levels exercising local autonomy to meet local situations. In practice, this autonomy makes it possible, in significant instances, for trade unions to participate in the delivery of health services by financing a supplementary supply of medical personnel, providing office space, or even operating sanitaria and recuperative facilities utilized by their workers. However, the health system is a State system and contributions of trade union, factory or workshop funds are merely supplementary.

When the delegation assessed its impressions of the scope of mental health in the Soviet Union, we agreed that it is far more narrow than it is in the United States. In Russia, mental health is identified as psychiatry, and mental health services are designed and provided as part of the medical program.

Individuals are referred to psychiatric facilities largely through medical channels—the medical units in schools or factories, the polyclinics, the physicians' home visits, or the medical emergency services. The specialized neuropsychiatric facilities—the NP dispensary, the mental hospital, the psychiatric ward of the general hospital—are all clearly defined as medical units. From the point of view of the mental health professional, the treatment system for psychiatric illnesses is parallel, but separate, from the major medical system. From the point of view of the patient, however, collaboration, consultation and referral procedures between the medical and psychiatric facilities are

The Ministry of Health, Moscow.

so routinely practiced that his physical and mental health needs are usually met without jurisdictional obstacles between the two medical networks.

The separation of the medical and psychiatric care systems is further illustrated by the fact that the Soviets operate health care networks for adults and separate but comparable health care networks for children. Additionally, separate Homes for Invalids are operated for senile psychotics and adult chronic patients; and these types of facilities are not regarded as part of the psychiatric care network; nor are they administered by the Ministry of Health, but rather by the Ministry of Social Security.

However, the delegation found that these administrative divisions did not seem to operate to the detriment of the patients. Since the basic operating principle of Soviet psychiatry is continuity of care, that care continues whether the patient remains in a specific inpatient facility, is transferred to another, or becomes an outpatient. When a patient returns to his family, he will in all likelihood be visited by a psychiatrist in his home. In the United States, such visits by psychiatrists are still considered to be innovations; but the typical Russian psychiatrist working in a neuropsychiatric dispensary is expected to make at least 20 home visits a month.

Dr. Dimitri Venediktov, Deputy Minister of Health.

Dr. Maya Shchirina, who accompanied the delegation, and Dr. Zoya Serebrjakova, Chief Specialist in Psychoneurology, Ministry of Health.

Of major significance in the Russian ability to provide continuing service to patients is its records system. The manner of keeping and storing records is archaic by American standards, but the records themselves are extensive and the system for transfer of the patient's records simultaneously with the transfer of the patient is impressive. In one Moscow polyclinic, for example, there were medical records of 30,000 of the 40,000 individuals resident in the clinic's service area.

In utilizing the resources available to him, the Russian psychiatrist is the key figure. He is aided by feldshers, nurses and other paramedical personnel, but the responsibility for decisions regarding the patient is his.

The professional role of the psychiatrist becomes paradoxical, in the American view, at this point, because—although the strong medical emphasis within Soviet mental health extends to all aspects of the system—the areas of medical concern go beyond those of medicine in the United States.

A typical Moscow apartment building.

Both Soviet and American mental health personnel are currently concerned in treating "the whole man" in relation to his entire environment. The difference in point of view stems from the differing tasks assigned to psychiatrists in the two systems.

In Russia, there is no profession of social work, and psychologists are not considered to be health professionals. The result, in practice, is that the Russian psychiatrist includes in his professional concerns the activities assigned to social workers and psychologists in the United States. The psychiatrist makes home visits; he is concerned with his patients' personal, family and work environment and he prescribes treatment based on these concerns. The range in prescribed treatment can be illustrated by the Russian attitude toward work as therapy.

Psychiatric patients in the Soviet Union are assigned to work therapy in every kind of psychiatric facility. Most of the facilities have workshops within their physical structure, and most mental patients work for some part of the day. However, Russian psychiatric practice includes the development of a clinical theory regarding work. One result of this is that it is the psychiatrist who assigns the type of work the patient will do while he is in the hospital and the type of work he will do when he returns to his factory or other place of employment. There are no occupational, recreational, or rehabilitation therapists per se in the Soviet Union. The profession of psychiatry encompasses them all and the psychiatrist is trained to practice these skills.

It must always be remembered, however, that he does so from his medical base. Russian psychiatry emphasizes the concept of illness and stresses the somatic etiology of mental illness. It assumes that mental disorders will often be recurrent and accepts the idea that many mental patients will need periodic hospitalization. For all their progress in providing community-based treatment, the Russians seem to accept the validity of their approach to mental illness on faith and are relatively unconcerned with the evaluation of their program.

A mentally ill person may be treated by chemotherapy, by work therapy, by periods of hospitalization, and by psychotherapy. But Russian psychotherapy, for the most part, is founded not on psychoanalysis or insight therapy, but rather on positive suggestion, behavioral conditioning and instruction in better ways to think and to live. It is within these treatment concepts that Russian psychiatrists practice and they do so with noteworthy clinical flair and an empirical ability to adapt treatment to individual patients.

Their attitude of confident optimism bears further comment. The present Russian medical system has been developed from a very weak base. In 1917, there were but 30,000 physicians and few of them practiced outside the major metropolitan areas of the Soviet Union. Currently there are over 525,000 physicians who are more densely and equitably spread throughout the country; and 35,000 medical students graduate each year.

Further, much of what Russians have accomplished in the field of health has been achieved within the past generation. The second World War resulted in massive destruction of Soviet hospitals and hospital beds. Thus, the development of the continuity of care framework, oriented to outpatient treatment and short-term hospitalization, was dictated as much by necessity as by conviction. This is reflected by the fact that the highly coordinated network developed by the Russians has not resulted in a reduction of hospital admissions. They have never felt they have had a sufficient number of hospital beds and they continue to press for mental hospital construction and additional beds for mental patients.

The key to the success of their program lies in the abundance of professional staff. The average neuropsychiatric dispensary, for example, typically has 15 to 25 psychiatrists on its staff and there are 19 such dispensaries in Moscow alone. Staffs of the medical units in factories are of comparable size. The automotive factory visited by the delegation in Moscow had a medical unit staffed by 150 physicians and 450 other medical personnel. It is true that this was the largest automobile factory in the Soviet Union but the size of the health service staff was reported to be similar elsewhere in relation to the number of factory employees.

By the same token, the emergency system is richly staffed by American standards. In Leningrad, for example, the psychiatric sub-station of the emergency service was operated by 11 psychiatrists—and 22 feldshers—all available for immediate ambulance duty.

The staff-patient ratios are equally impressive in the urban mental hospitals. At the Kashchenko Mental Hospital in Moscow, there were 160 psychiatrists and 2600 beds—a 1 to 16 ratio. Similarly, there were more than 800 nurses. At the Vinnitsa Mental Hospital with 1,900 patients there were more than 100 physicians of whom 87 were psychiatrists, more than 450 nurses and over 700 ward orderlies. Over all, the patient-staff ratios were virtually 1:1.

On a ward of some 100 beds at the Ramenskoy Hospital, which is both a rural as well as a chronic facility, we found only three physicians, but even here there were 25 nurses and 35 ward aides.

What then, are the major conclusions of the U.S. Mission on Mental Health? In general terms, there can be no doubt that the Russians have developed a *framework* for the delivery of psychiatric care that is remarkable to the extent that it attempts to provide—and to a considerable degree does provide—a readily available, geographically accessible network of coordinated facilities.

This network is unique in a number of respects. First, while it is an extension of the system of medical services and receives its patients from that system, it is largely separate from it. At the most likely point of contact, for example—the general hospital—there is little psychiatric representation. While the Russians claim they are establishing more psychiatric wards in general hospitals, it was the delegation's impression that there was little "grass roots" support for such a development, and that in any event it would be of limited scope focusing primarily on psychosomatic cases and mild neuroses.

Second, the most powerful and prestigious unit in the mental health delivery system is the mental hospital. It is at the mental hospital that many of the Chairs of Psychiatry are located and it is here that much of the specialized psychiatric training takes place.

Another point worth pondering is that while the Russian system is highly organized and bureaucratic, this is not reflected in a lack of concern for the individual patient. Time and again, the delegation was impressed with the sensitive concern and individual attention shown psychiatric patients—agitated schizophrenics and senile psychotics included.

The question of how effective this network is must be answered on an impressionistic level. There are no national statistics on the prevalence of

The Hotel Budapest was the delegation's Moscow headquarters.

mental disorder in the Soviet Union and local statistics are likely to be inadequate. However, the delegation was of the opinion that the system *was* effective, particularly in the urban areas.

This is not to say that there are not weaknesses in the framework. The scope of mental health is considerably more limited than in the United States. Further, the Russians have yet to refine non-medical professional mental health roles to any significant degree. There are still inequities in the distribution of health professionals—despite the high degree of organization of the care network—and the quality of the uchastok physician, or "family doctor", seems a particular problem.

What can we draw from the Russian framework? A word of caution is in order. The Russian network of care reflects a particular and unique socio-political-cultural system. We cannot seek to imitate an essentially alien system; we can, however, adapt and apply relevant principles.

Within this framework, there is much to consider. We should attend to the Russian solutions to the manpower problem. The effective and large scale employment of women in the health system is especially striking. So too, is the role of the feldsher—a medical technician between the level of nurse and physician.

The emergency system also warrants special attention. Crisis intervention is more than a phrase; it is an essential and critical component of the psychiatric program and in the Soviet Union it is richly staffed and supported. It is an enviable aspect of their program.

The key emphasis, however, is on continuity of care, and that is of no less import for the United States than for the Soviet Union. We need to develop, promote and support greater coordination and more effective collaboration among our mental health facilities and resources.

In conclusion, then, it is clear that the Russians have made considerable progress toward the development and articulation of a framework that is in keeping with their national goals.

From the delegation's perspective there are questions which remain unresolved, implications which have yet to be determined and areas which are in need of further study. However, there is consensus that the mission was a valuable and enlightening experience. Through a continuation of visits and exchanges we should be able to continue to expand our knowledge in providing mental health services. As this mission has demonstrated, this can be done in an atmosphere of mutual instruction, understanding and respect.

Organization, Planning, and Funding of Health Services

ORGANIZATION OF HEALTH CARE

In most countries of the western world, as the World Health Organization has noted, the provision of medical care is fragmented among three sectors of the economy: the private physician working on a fee-for-service basis; the locally controlled and financed hospital; and the public health services, financed by Federal, State and/or local governments.

The Russian health system, in contrast, has established a national health service through which medical care is provided free of charge to all citizens and is totally financed by public funds.

Over the past five decades, the Russians have developed and tested a mechanism for delivery of health services which has dramatically improved the health of the Russian people. In 1913, 43 percent of all Russian children died before the age of five; today, less than five percent of children die before the age of five. In 1913, the average life expectancy of a Russian citizen was 32 years; today, it is more than 70 years.

The Ministry of Health of the U.S.S.R., founded in 1936 as the successor organization to the Peoples Commissariat for Public Health, is the supreme administrative authority charged with the responsibility for maintaining the health of 230 million Russian people.

The Minister of Health is appointed to his post by the Supreme Soviet of the Soviet Union, which is the highest parliamentary body in the country. He is a member of the Council of Ministers, which would be comparable to the Federal Cabinet in the United States.

The Ministry of Health has an extremely broad mandate in the planning and development of all types of health services, devising standards and strategies for the training of all health personnel, the supervision and design of research, control of all drugs and pharmaceuticals and over-all supervision of the health activities of all the Republics within the Soviet Union.

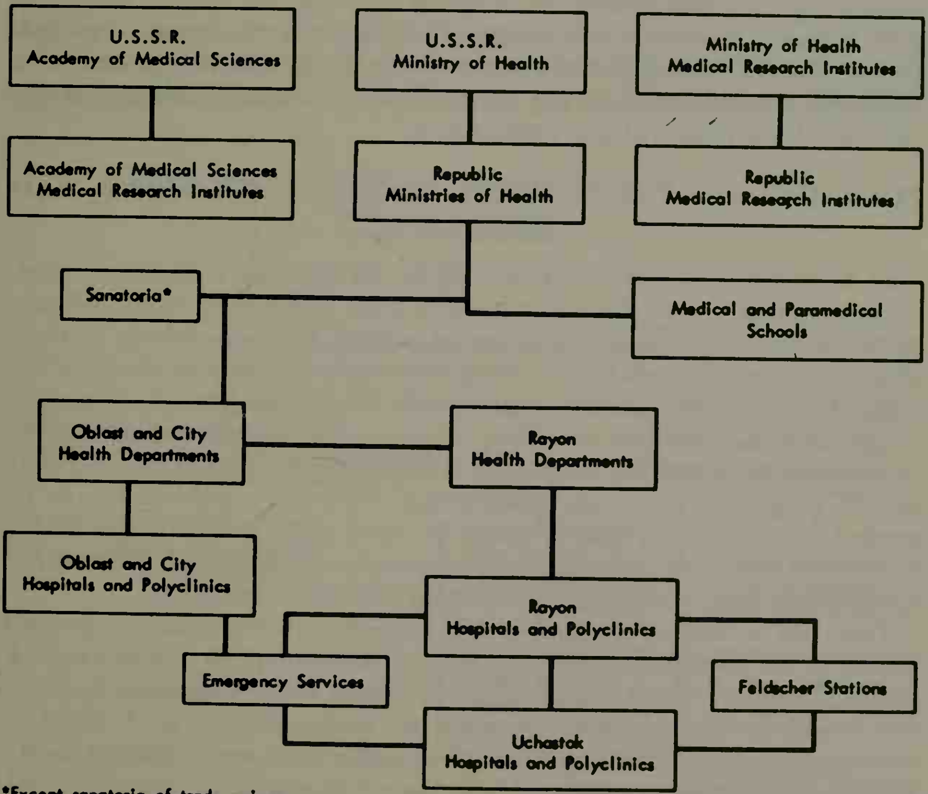
To aid it in discharging these many tasks, it has eleven departments staffed by highly qualified specialists. Key sections include the Department of Curative and Preventive Medicine, which is responsible for medical treatment for all adults in hospitals, polyclinics and other facilities; the Department of Medical Personnel and Higher Education, charged with supervision of all medical and paramedical schools and graduate and postgraduate education of health personnel; and the Department of Planning and Finance, which develops long-range projections for construction of facilities and the training of personnel, promulgates minimum standards in these areas and allocates the money supplied to it by the Ministry of Health for all of these resources.

The chief specialist in psychiatry is a key member of the Ministry of Health staff; she is a highly respected advisor to the Minister of Health.

The most powerful advisory arm of the Ministry of Health is the Academy of Medical Sciences, founded in 1944. The Academy is composed of physicians who are elected to it from among the ranks of doctors in academic medicine. Membership in the Academy is the highest accolade that can be awarded to a Russian doctor. Although the Ministry of Health supplies the funds for support of the Academy, in many ways it enjoys co-equal, or even superior, status to departmental officials working for the Ministry. For example, most of the medical research in the Soviet Union, although carried out in many special research institutes, is planned and supervised under the aegis of the Academy of Medical Science.

In the field of psychiatry, the Institute of Psychiatry of the Academy of Medical Science plays a powerful policy role. Its director, Dr. A. V. Snezhnevsky, is probably Russia's most distinguished psychiatrist and his influence is felt at all levels within the Ministry of Health.

While over-all responsibility and final decision-making in the health field


U.S.S.R.
Academy of Medical Sciences
U.S.S.R.
Ministry of Health
Ministry of Health
Medical Research Institutes
Academy of Medical Sciences
Medical Research Institutes
Republic
Ministries of Health
Republic
Medical Research Institutes
Sanatoria*
Medical and Paramedical Schools
Oblast and City
Health Departments
Rayon
Health Departments
Oblast and City
Hospitals and Polyclinics
Rayon
Hospitals and Polyclinics
Emergency Services
Feldscher Stations
Uchastok
Hospitals and Polyclinics

*Except sanatoria of trade unions.

Structure of the Health Services in the U.S.S.R.

resides theoretically in Moscow, in actual practice the Health Ministries of the large Republics of the U.S.S.R. have their own budget and planning mechanisms. The Minister of Health of a large Republic, such as the Russian Soviet Federated Socialist Republic (with a population of 100 million) or the Republic of the Ukraine, has a highly-qualified administrative health staff which develops medical service, training and research goals to meet the needs and potentialities of the particular Republic. In our delegation's many conversations with these individuals at the Republic level, we found them knowledgeably opinionated and at times critical of the edicts of the Ministry of Health in Moscow. These attitudes are illustrative of the growing tendency towards decentralization and local planning in the Soviet Union.

There is a continuing review and reappraisal of psychiatric research trends in the U.S.S.R. The Institute of Psychiatry of the Academy of Medical Sciences in Moscow does the major over-all planning. Research is actually carried out in eight special research Institutes, in addition to the 80 departments of psychiatry in the various medical institutes. In practice, there is a great deal of give and take in setting research goals. For example, the Problem Committee for Research in Psychiatry, which meets frequently at the offices of the Institute of Psychiatry, is composed of the heads of all the medical institutes and their outstanding research workers; there is frequently quite vigorous discussion and disagreement before a consensus is reached. In our tours of research installations, we discovered that the director of a particular research institute was the single most powerful influence in the ideological orientation of that organization.

PLANNING OF PSYCHIATRIC SERVICES, TRAINING AND RESEARCH

In a society in which the state operates all psychiatric facilities, long-range planning can be directly related to what government health officials regard as the major needs of the mental patient. We saw evidence of these efforts in impressively staffed planning units in the Ministry of Health of the U.S.S.R., and in the various local Health Ministries. There is a continuing discussion of relative priorities—whether relatively scarce funds should be allocated to improving the mental hospital, expanding the reach of out-patient psychiatric facilities, constructing additional psychiatric units in general hospitals, or to other projects. In rural areas, where mental health services are frequently sparse, there is constant examination of the need for constructing new facilities and recruiting additional staff.

There are obvious advantages to this kind of universal planning, as contrasted to the situation in America where 50 States adopt 50 different mental health plans, and where mental health personnel locate themselves by their own free choice. For example, in creating new medical schools, the U.S.S.R. is concentrating upon those Republics which suffer from severe medical shortages. In constructing new hospital beds, there is an emphasis upon additional facilities in rural areas. This is not to imply that one monolithic plan is developed in the Ministry of Health of the U.S.S.R. and then handed down to the provinces. As with research, the delegation saw evidence of vigorous give and take between the U.S.S.R. officials and the local health administrators, who are not afraid to present alternatives when they feel a particular plan is not suitable to the needs in their area.

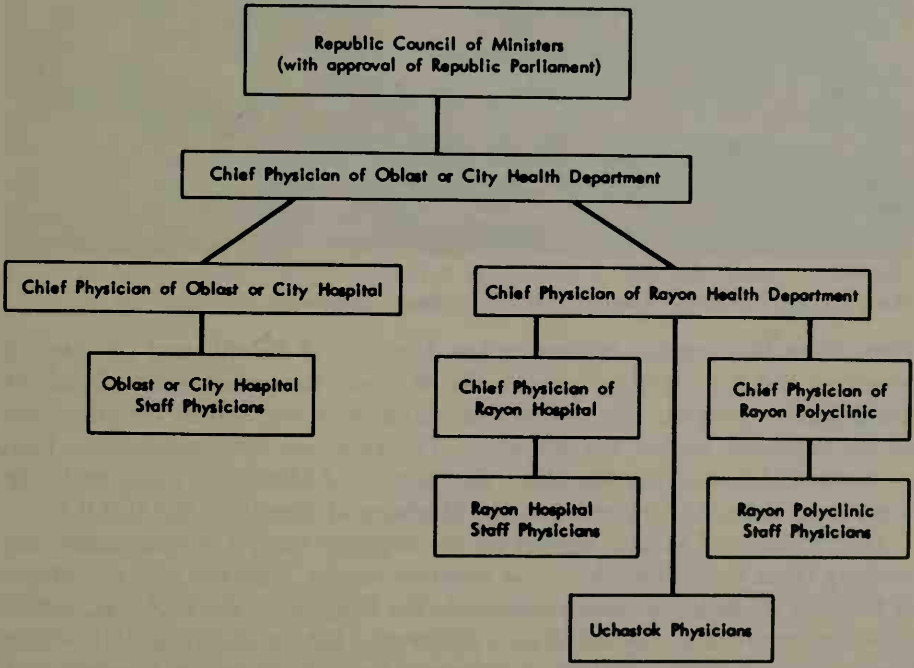
The intensity of this planning effort is best illustrated in the area of health personnel. Starting 50 years ago with crippling shortages of all types of medical personnel, the Russians have given the highest priority to the nurturing and development of a powerful network of training installations. (See Manpower and Training.)

FUNDING OF HEALTH CARE

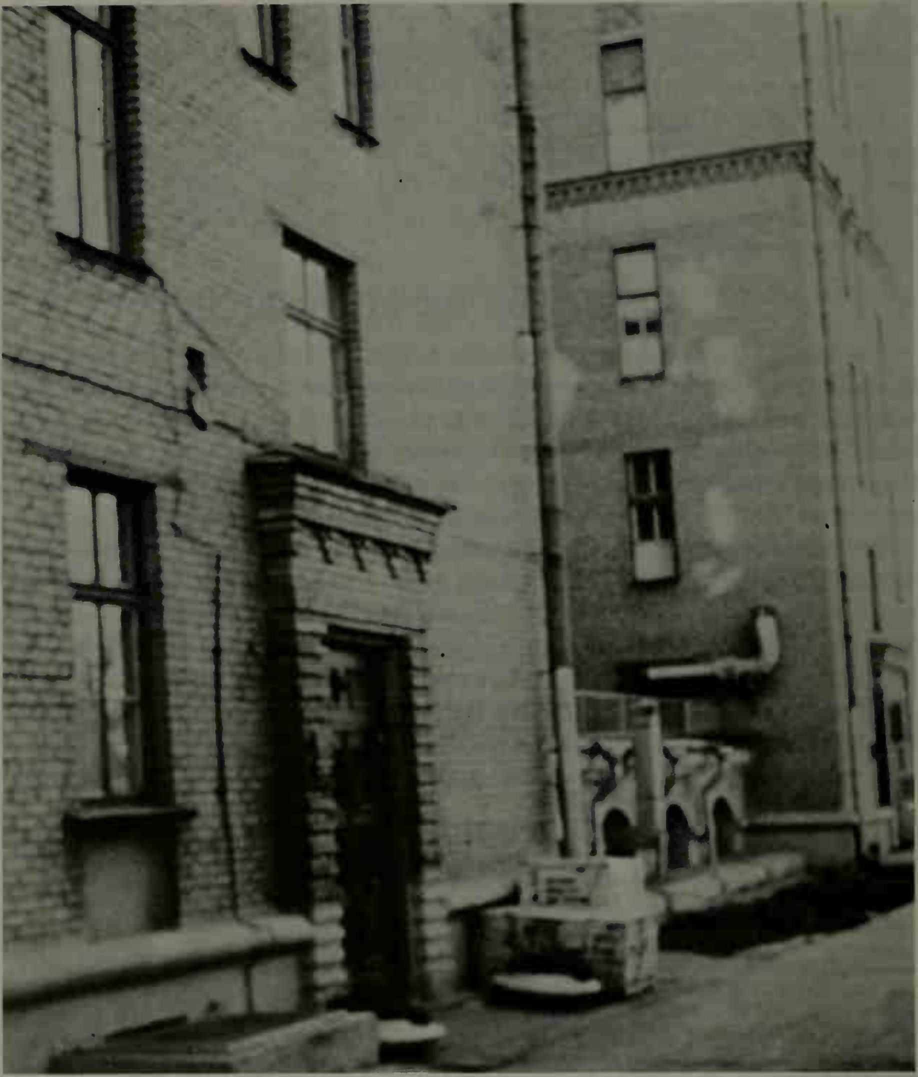
The budget-making process is another illustration of the visible degree of flexibility present in the Russian health care system. Although the central Ministry of Health of the U.S.S.R. sets general standards, such as the number of hospital beds per patient and number of health personnel per patient, the grass roots institutions and agencies actually translate these formal and sometimes idealistic guidelines into specific budgets.

The budget process really begins with the requests of hospital superintendents and the NP dispensary directors at the local level. These are reviewed by regional health authorities, which then forward their recommendations to "oblast" health directors (an oblast is a large segment of a Republic, usually covering one million people or more).

When the oblast health directors have completed their review, all recommendations are forwarded to the Health Ministry of the particular Republic.


Republic Council of Ministers (with approval of Republic Parliament)
Chief Physician of Oblast or City Health Department
Chief Physician of Oblast or City Hospital
Chief Physician of Rayon Health Department
Oblast or City Hospital Staff Physicians
Chief Physician of Rayon Hospital
Chief Physician of Rayon Polyclinic
Rayon Hospital Staff Physicians
Rayon Polyclinic Staff Physicians
Uchastok Physicians

Chain of Physician Appointments in the Soviet Health System.



The Institute of Psychiatry, Academy of Medical Sciences, Moscow.

Here there is a careful review by the Minister of Health and his various planning and finance departments. The Minister then meets with officials of the Republic Gosplan, the central financial agency responsible for allocation of all resources within the Republic. The Gosplan recommendations then go to the Cabinet of the Republic, the Council of Ministers. Then, and only then, is an estimate forwarded to the Ministry of Health of the U.S.S.R.

The Ministry of Health screens all the Republic budget recommendations, relating them to total needs in the fields of service, research and education. It then forwards its recommendations to the Gosplan of the U.S.S.R., which allocates resources to the health care program, while considering all the other needs of the country—including industry, agriculture, space, housing, and general education. After it clears the Gosplan, the final budget goes to the

U.S.S.R. Council of Ministers (the Russian Cabinet). It is reported that there is vigorous and free discussion of these proposals at the Cabinet level. The Minister of Health told our delegation, with a smile, that he never gets all of the money he wants from the government, but he assured us that he was allowed to argue quite strongly for what he felt was the necessary funding level to support this program.

FUTURE PLANNING

At the delegation's final briefing at the Ministry of Health, we were given an outline of future plans for the delivery of psychiatric services in the U.S.S.R. These were the major points:

1. More specialized mental hospitals must be built because of the shortage of beds. No new hospitals will exceed 500 beds.
2. Since it is not economically sound to construct small mental hospitals of from 50 to 100 beds, smaller psychiatric units would be included in general hospitals or neuropsychiatric dispensaries. (This future plan represents a change from present practice.)
3. In an effort to bring psychiatric outpatient services closer to the people, the Russian plans call for strengthening the range of services in NP dispensaries and to include more day hospitals within these facilities. They also plan to improve treatment of persons with psychosomatic disorders by general physicians through further physician education. In this way, they hope to increase the acumen in diagnosis, so that patients are more promptly given appropriate treatment.
4. In planning psychiatric facilities for children, there has been a vacillation in Soviet policy. First, children were cared for on wards within the mental hospitals. At the time of the visit of the U.S. Mission, they were being cared for in separate children's hospitals and children's psychiatric facilities with some ambivalence being expressed as to the preferred method.

It was evident that the Russians are experimenting, as we are in America, with many new types of psychiatric services. They have a flexible and experimental attitude and much of what they may declare to be clear-cut planning policy is subject to modification or change, on the basis of experience in the field.

Channels of Entry Into the Psychiatric Service System

THE POLYCLINIC

When the government of the Soviet Union was established in 1917, one of its first decrees stressed that the protection of the health of the population, the organization of medical assistance available to all, and the creation of optimal living conditions represented a government problem of primary importance.

Statute 120 of the constitution stipulates: "The citizens of the U.S.S.R. have the right to material assistance in their old age and during illness and inability to work."

On this basis, through the intervening years, the organization of health care has developed from the basic principle of prevention, which dominates the activity of all medical centers in the U.S.S.R. Soviet public health organization is developing in two directions: termed "curative-prophylactic" and "sanitary-hygienic."

The medico-prophylactic part of public health includes the activity of the hospitals, polyclinics, outpatient clinics, dispensaries, medical health units of industrial establishments, district hospitals, hospitals in rural regions and midwife stations in villages.

The Soviet health system is a new system, begun fifty years ago and developed through major periods of interruption—the greatest of which was the second World War.

When members of the first U.S. Mission on Mental Health arrived in Russia in September 1967, our first need—in order to observe and evaluate the Russian organization of mental health services and treatment of the mentally ill—was to secure an understanding of the general health services system. Treatment of psychiatric illness is provided, for the most part, in a separate network of facilities which parallel and are complementary to general health facilities. But, from the point of view of the Russian consumer of those services, his usual entry into mental health or other specialized care begins in one of the general health facilities.

In most instances, this is the polyclinic, located closest to his home and familiar to all residents of the district as the neighborhood health facility. From the time that his mother is visited at her home, during her fifth month of pregnancy, until his death, the Russian citizen has a continuing, personal relationship with his polyclinic and its staff. Until the age of 18, Russian youngsters go to the children's polyclinic, for the Russian health system—both in general medicine and in psychiatric care—separates the network of children's services from those provided for adults. There are indications that this plan may be changing in terms of hospitalized mental patients, but traditional patterns of organization are based on the belief that children have special medical and social needs and problems that can best be solved by specially trained personnel of whom the pediatrician is the central figure.

Polyclinic #77, Moscow. Polyclinics are neighborhood health facilities.

(See Children's Care Network). From the age of 18, the adult polyclinic assumes the active supervision of the health needs of all individuals within its geographic jurisdiction. The Russian worker has a choice: he may secure medical and health services from the polyclinic which is part of his factory medical unit, or he may choose to frequent his polyclinic of residence. In either instance, his medical records, history and progress are available to both clinics and interchanged when the situation requires coordination between the two facilities. For the population which does not work (mainly housewives and the elderly), the polyclinic in his neighborhood is his port of call, and if he doesn't call on them, the staff will call on him.

The average city polyclinic serves 40,000 adults in its district or "ryon." In order to gain a more intimate contact with patients, the district is further divided into microdistricts, "uchastoks," serving from 3,000 to 4,000 adults. The general practitioner for that microdistrict—the uchastok doctor—is comparable to the family doctor in the United States. His office is located in the polyclinic and it is he, supported by nursing staff and other personnel, who provides the individual professional liaison among the polyclinic, school health unit, factory health unit, and dispensary in the general health program. He also provides liaison between the people of his uchastok and facilities within the psychiatric care network.

In the Russian health system, however, the "family doctor" is aided, in addition to nursing staff, by a "feldsher," who has received four years of medical training and is assigned to treat minor medical ailments and perform minor surgery.

Because the U.S.S.R. is heavily supplied with medical personnel, the polyclinics are well-staffed. They are open from 8 a.m. to 9 p.m.; a doctor is always on hand to take care of emergencies after 9 p.m.; and since they are readily accessible, the polyclinics succeed in reaching most of the people within their jurisdiction.

In Polyclinic #77 in Moscow, for example, there are medical records of 30,000 people in the district population of 40,000.

One of the great strengths of the polyclinic is its coordination with other units of the medical network. Particularly close is the relationship between the polyclinic and the general hospital, which could be regarded as a model for coordination between facilities in the specialized medical care systems.

Patients at the polyclinic in need of inpatient treatment are referred to the appropriate hospital. Referral has none of the amorphous quality associated with the term in the United States; and it includes the transfer of medical records and follow-up.

After a patient's initial period of hospitalization, the polyclinic physician responsible for his outpatient care consults with the hospital physician. Since the emphasis of the entire health network is focused on a continuity of care, the polyclinic physician will be fully informed of the patient's progress and condition when he is discharged, and his follow-up care will proceed, for the polyclinic is not a passive agency, waiting for patients to seek it out. While there is no door-to-door screening, there is an active attempt to have all persons within the district come in for an annual physical examination and special attention is paid to people who, ordinarily, are difficult to reach, such

ПОЛИКЛИНИКА

Dr. G. M. Morozov, Director, Mme. Modestova, interpreter, and Dr. Alan Miller at the entrance of Polyclinic #77, Moscow.

as the aged. If the patient's diagnosis is such that observation or follow-up care is deemed necessary, the polyclinic will attempt to have him examined at least twice a year. If the patient does not respond to the card requesting him to visit the polyclinic, he will be visited at home by the nurse and, in some cases, the physician assigned to his district.

The delegation noted that there was a marked opportunity for "personal care" in medicine as practiced in the polyclinic. Each uchastok physician, although located at the polyclinic, is responsible only for the medical care of the population in his jurisdiction. Through the added mechanism of home visits, the physician gains—at least in theory—a more intimate understanding of the patient and his situation.

Although there are medical specialists located at the polyclinic as well, they do not ordinarily provide specialized psychiatric services. In the larger polyclinics, there is a psychiatrist or a neurologist on the staff. They often treat mild neuroses, or deal with emotional disturbance, especially when it is accompanied by physical illness. Such patients are treated for symptomatic relief; if the complaint persists, they are referred to the specialized neuropsychiatric dispensary, with which the polyclinic maintains a consultative relationship.

It is at this juncture that—having observed the structure and operation of the basic facility for health care—the delegation turned its attention to the psychiatric services—the purpose of our visit—convinced that the greatest impact of the polyclinic lies in its operation as the focal point in a coordinated care network. Through a close and effective liaison with a wide variety of medical, social security, welfare and educational agencies, the polyclinic is effectively able to treat, when possible, and to refer, when necessary. It is the single best example of the Russian medical framework in action.

FACTORY HEALTH UNITS

The factory medical unit is, in many ways, the most unusual and dynamic health facility in Russia. It is, of course, highly accessible to all workers. In small plants, the unit may consist of a first aid station staffed by a feldsher; but in large factories, the medical units are usually superior to the district polyclinics and hospitals.

At the Likhachov Motor Car factory in Moscow, for example, where some 70,000 persons are employed in the production of ZIL automobiles, trucks and other equipment, the medical unit is staffed by 600 workers, including 150 physicians and from 250 to 270 paramedical workers and handles some 2,600 patients during a typical work day.

The delegation's observations indicated that the factory medical unit did not specialize in early detection of neuropsychiatric disorders but, from the standpoint of comprehensive health care, these medical units emphasize preventive services of several types which have close relationships to the mental as well as the somatic health of the employees.

These units are operated—as distinct from the district polyclinics—because of the Russian belief that it is possible to provide better service to workers through industrial physicians who understand the work situation, the need for safety promotion and for health education. The units have extensive facilities which make it possible for them to screen, diagnose and treat patients—at their place of work—in a comprehensive range of medical departments. The polyclinic at the ZIL factory, for example, in addition to departments of internal medicine, surgery, gynecology, obstetrics, tuberculosis, skin, eye, dental, X-ray, functional diagnosis, neurology and many others, has its own inpatient service, a TB sanitarium of 100 beds, a special dining hall for employees with dietary problems, and twenty-two smaller medical units, scattered through the plant to provide emergency service.

Its doctors are specialists and highly trained consultants from the Institute of Therapy of the Academy of Medical Sciences, the Research Institute, the Institute of Industrial Hygiene and Occupational Diseases, and the Institute of Traumatology and Orthopedics.

All factories have large budgets for medical care. While professional salaries are paid by the local ministry of health, all other services are provided from factory income. As an inducement to medical personnel—in addition to the high quality of the facilities themselves—factory medical units can offer doctors and other medical personnel excellent fringe benefits. The factories, for example, have a high priority in securing scarce apartments; they operate rest homes in the Crimea and elsewhere, and general working conditions attract the highest quality of medical personnel. Our delegation's primary interest in the industrial health units, however, was the manner in which they considered psychiatric illness and the facilities available to mentally disturbed workers.

In the ZIL factory unit, there were nine neurologists on the staff who handled many of the neuroses. In most instances, the procedure for employees who needed treatment for mental illness required referral to the NP dispensary serving his home area, since there are no psychiatric beds in the factory.

There is a psychiatric unit, however, which took care of approximately 30 visits a day. The staff's concern seemed to focus on maintenance of former mental patients on the job. It was noted that workers with mental disorders were specially listed and the record cards include notes that they are to be observed and given special support. One of the foremen commented, during our visit, that when a worker has an emotional problem, his fellow workers try to help and if they do not succeed, suggest that the worker go to the medical unit.

Possibly, because of the proximity of health services and the workers' routine acceptance and use of them, the stigma of mental illness was not obvious either among the staff or the workers. Specifically, the staff stated emphatically that the accident rate for former mental patients is no higher than for other workers and that, actually, the reverse is true.

The objective of the factory medical staff is to keep the worker on the job, in good health, and free of accidents. One result is that the worker has some freedom of choice; he can seek treatment in his factory health unit, or he can be treated in his home district facilities. The liaison between professionals in the various facilities seemed to be unhampered by jurisdictional prerogatives. Unlike the district polyclinic physicians, factory doctors rarely make home visits. However, if a doctor from a NP dispensary or a mental hospital recommends sanitarium care for a worker, the factory usually allows him to use plant facilities. When the worker is recovered, he is assigned to a job for which he has the skills, and the administration is alerted to observe his progress and reassign him if necessary.

Factory medical units have specific methods of providing their share of the total health care available to all Russian citizens. Special attention, for example, is given adolescents who work in the factory. The adolescent unit, under supervision of a pediatrician, offers follow-up treatment prescribed by other departments, and careful supervision to make sure that the individual works within his capacity.

The occupational unit is concerned with such industrial hazards as air pollution, noise levels, and vibration levels, all of which are measured and studied, as are the effects of contact with lead, benzol and other toxic products.

The 12,000 workers who have hazardous occupations at the ZIL plant are examined once a year, or twice a year for high risk job holders. All employees have an annual fluoroscopic examination; all women pay annual visits to the gynecology and cancer detection unit; and all adolescents are required to have an annual physical examination.

A sanitarium of 100 beds is available for neurological and cardiovascular diseases and for gastric disorders; and there are rest and relaxation spas in the Crimea. Other preventive programs include hypertension, gastric ulcers, and vitamin therapy. A 1,100-bed hospital was currently under construction to reinforce the polyclinic's operation.

The ZIL factory and others include a treatment program for alcoholism,

The Polyclinic for workers at the ZIL motor car factory.

but they find detection and treatment difficult, because workers tend to "cover up" for those who drink, and to hide alcoholism from the authorities. There is, however, a factory narcologist who works solely in the treatment and rehabilitation of alcoholics. In addition to aversive therapies, the narcologist devotes a considerable time to assessing the work situation and job capacity of his alcoholic patients. If he finds the job inappropriate, he recommends transfer of the alcoholic to another work unit.

From our limited observations, the delegation gained the distinct impression that the Russian worker has excellent medical care available to him. Additionally, it appeared that although inpatient psychiatric care was not provided within the factory facilities, supportive outpatient care was available which, when coupled with support of the emotionally-disturbed worker on the job, made it possible for the individual to continue to work and to be accepted by his fellows and his community.

EMERGENCY SERVICES

When a resident of a Russian city dials "03" from a phone in any part of town, the emergency health service goes into immediate action. This highly skilled and mobile team is trained to meet psychiatric as well as medical emergencies around the clock. The system, particularly in Leningrad, is a dramatic illustration of the Soviet ability to provide, in practice, the comprehensive health care to which the state is committed, beginning at the time and place of crisis. For the victim of an acute psychiatric episode, the psychiatric emergency service provides the immediate point of entry into the network of facilities available for psychiatric treatment and rehabilitation.

Every city, or geographic district for which the emergency service is responsible, includes a central unit serving as a communication-coordination center. Russians call "01" for fire, "02" for police, and "03" for health emergencies. All calls are received by a clerk in the central unit, recorded, and relayed to a dispatcher who, in the case of "03" calls, routes the information to an appropriate substation for action.

In Leningrad, fourteen such substations are located throughout the city and the substation to which psychiatric emergencies are assigned is Number 13.

Each of the emergency substations is equipped with seven ambulances and the corresponding medical team, made up of a physician—in the case of a team from #13, the physician is a psychiatrist—two feldshers and a driver, all of whom are aboard when the ambulance leaves its substation, approximately three minutes after the initial call is received.

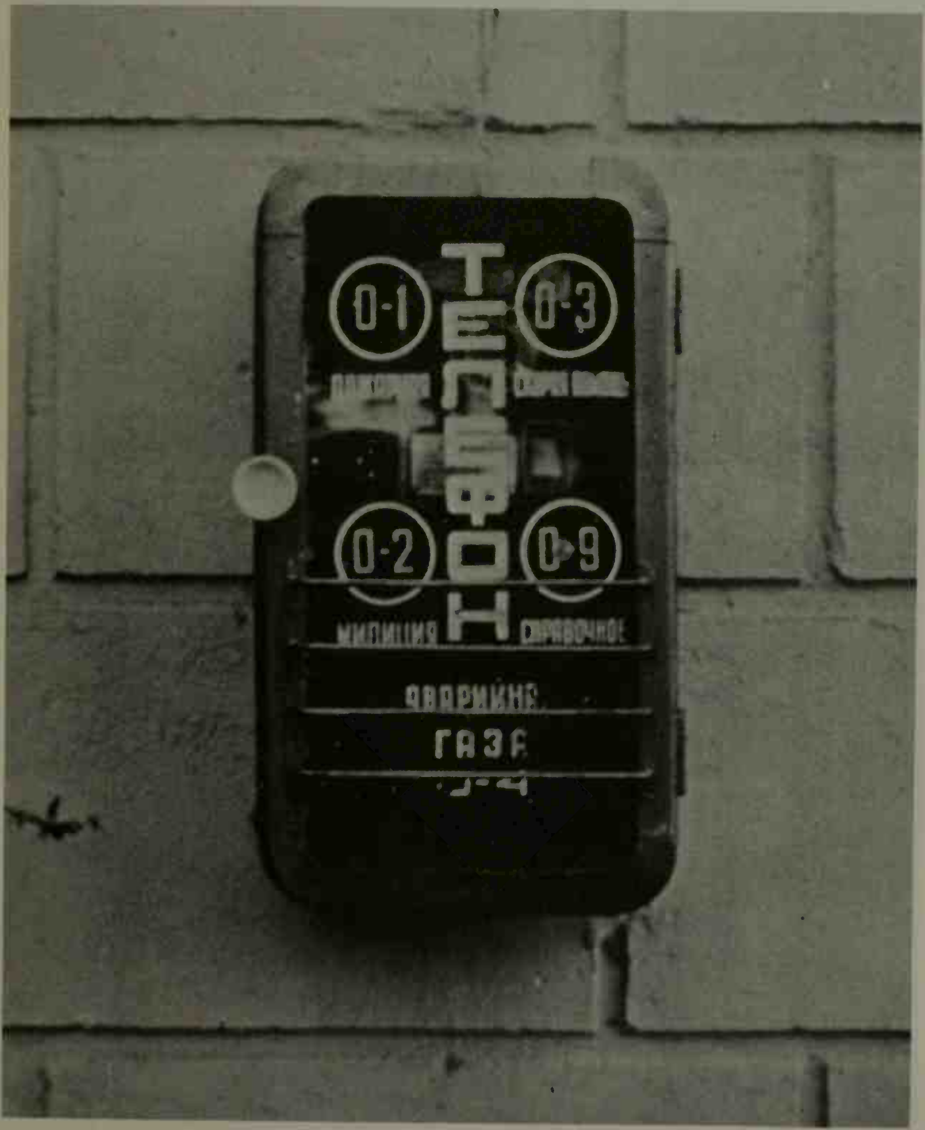
If it is obvious to the central dispatcher that a psychiatrist is required to meet the emergency, substation #13 is called by him directly. If the nature of the emergency is not obvious to him, the emergency team sent to the site will call for the psychiatric team. To meet its responsibilities, #13 is staffed by eleven psychiatrists and 22 feldshers.

All teams are trained to give emergency care, and physicians assigned to emergency duty are now required to take special training under a newly established faculty. Usually, three years of experience is required before a physician can qualify for emergency service.

There are 28 physicians on the Leningrad Substation #13 service staff; each is on duty for 6½ hours; there is a minimum of four ambulances available day or night. The emergency physician takes the patient directly to the hospital, to the polyclinic or the dispensary. An ambulance receives from ten to 13 calls in a 24-hour period. The average station answers some 75 calls per day.

Two-way radios conserve time and distance.

Our delegation was impressed with the excellence of the equipment; the



Public telephone. Health emergency number is "03."

variety of kits available for resuscitation, auto-trauma, cardiac collapse, poisoning, burns, shock and others; and the efficiency of the operation from the point of the first cry for help to the response of the ambulance and medical team in arriving at that point.

In observing the operation, it was evident that a psychiatrist, with his feldshers, could respond to a psychiatric emergency within less than ten minutes from the time #13 received the call.

The psychiatrist with whom the delegation talked indicated that his

Dr. Stanley Yolles and Dr. Phillip Sirotkin visit a Leningrad emergency substation.

substation provide all of the first aid and emergency care for psychiatric emergencies during the night—from 8 p.m. until 9 a.m. During the day, they also serve factories, offices and street accidents as well. All other pyschiatric emergency day-time calls are the responsibility of the neuropsychiatric dispensary in the appropriate district.

Substation #13 keeps three brigades on duty at all times: a doctor, two feldshers and a driver. In addition to responding to emergencies, they provide transport of patients to the hospital at the request of doctors' offices, dispensaries, or polyclinics.

If they are unsuccessful in persuading a psychiatric patient to accompany them, the police are called, but a psychiatrist must always signs a certificate

Ambulances outside Leningrad emergency substation.

Judge David Bazelon at a Leningrad emergency substation.

for the observation or admission of a patient, and the disposition of the emergency case is subject to appeal before an expert committee. Suicidal threats are also referred to #13, where the station receives an average of ten to 12 emergency calls each night.

The Leningrad service is regarded as excellent because it is tied so closely to the central station, where a physician is always on duty to check the data and make the proper referral to a specialized team.

In the Moscow service, the psychiatric emergency unit operates apart from the central service, so that equally rapid screening is not always possible. However, despite the individual differences between areas, the delegation was highly impressed with the framework for provision of health emergency coverage—especially by the Russian recognition of the problem and the concept of psychiatric emergencies.

System of Delivery of Psychiatric Services

THE NEUROPSYCHIATRIC DISPENSARY

In many ways, the neuropsychiatric dispensary is the most important treatment facility in Soviet psychiatry. Broadly analogous to the polyclinic, the NP dispensary is the nucleus of the specialized psychiatric service network and emerges as the focal point of the system for delivery of psychiatric services.

NP dispensaries are distributed throughout the Soviet Union, paralleling the geographic regional organization of Soviet government. Ordinarily, dispensaries are located so as to serve a region (ryon) of from 300,000 to 400,000 persons. There is a flexibility in their placement, however, and the delegation was told that there were 19 NP dispensaries serving Moscow's 17 regions; in the city, therefore, the NP dispensary is only ten minutes away from home by public transportation.

Its effectiveness is also related to the large staff which handles a very high patient load, both at the dispensary itself and in the community. The average dispensary can call upon from 15 to 25 staff psychiatrists.

In urban areas, few dispensaries have inpatient beds, since there are alternate facilities for hospitalization. In rural areas, the dispensaries may have as many as one hundred beds, providing inpatient services to a large percentage of patients in the area who are acutely ill. Every dispensary has a workshop and a few also have day hospitals.

As part of the program to promote and maintain continuity of care, the dispensaries work in close cooperation with the mental hospitals in the area. Although the dispensary may be located within the hospital proper, they are usually freestanding units.

The NP dispensary is the primary outpatient facility for treatment of adults and, in separate departments, children with psychiatric disorders, but its responsibilities extend beyond the treatment area. Reflecting the Russian conviction that effective prevention is as necessary as treatment, the dispensary is designed to be a psychiatric-prophylactic-consultation center. Its single objective is to provide a broad range of readily available and geographically accessible psychiatric services.

These services usually begin as outpatient services, provided at the dispensary, but home treatment also exists and is one of the major strengths of Soviet psychiatry. The average dispensary psychiatrist makes at least 20 home visits a month in Russia. In making such visits, he can, in addition to prescribing treatment, assess the whole family and its social milieu as it relates to the specific mental illness of the patient under treatment. In many cases, the psychiatrist makes what amounts to socio-medical recommendations based upon the assessment of the patient's total environment.

This degree of knowledge of the patient is necessary, if the dispensary staff is to fulfill the obligations of the facility as designed and planned by the Ministry of Health. For the dispensary, in addition to its preventive and treatment work, is also deeply involved in the rehabilitation of patients and their maintenance in society. Its special concern is for the social recovery and the restoration of the mental patient's working capacity. This is particularly true since most patients who remain under the supervision of the NP dispensary are individuals who are no longer acutely ill, but who need continuing rehabilitative support.

This support is achieved, for the most part, in the Russian rehabilitative system, by assigning them to "useful work." Many patients, for example,

A regional Neuropsychiatric Dispensary, Moscow.

have completely, or almost completely, recovered from their psychoses. They may have received a leave of absence from their jobs in order to be treated, and are expected to resume their professional activities at the same level as before their illness.

For this group, the NP dispensary staff assumes the responsibility of recommending extension of leave, when necessary, or assuring the patient of optimal working conditions to prevent occurrence of situations which might have an adverse effect on his mental state. During such a period, the staff also checks the patient's work performance and the effect of the work he performs on his mental condition.

There are other patients who have been discharged from the mental hospital during a remission, or whose condition is still unsatisfactory, even though extended inpatient care is not necessary. In these cases, Russian psychiatric practice utilizes work therapy (ergotherapy) as the principal vehicle in the patient's readjustment to society. This work therapy is applied in workshops within the NP dispensary, to exert a therapeutic effect on the patient. Additionally, the staff teaches new vocational skills to give the patient a new profession compatible with his working capacity, and they help him to find suitable work when he is ready to resume outside employment.

The emphasis on prevention, therefore, continues during the rehabilitative stages of an individual's illness and should not be viewed as a separate component of the dispensary's activity, for it pervades the program.

Thus, while a major effort of the dispensary lies in the discovery and identification of mental disorder in the general population and the maintenance of patients in the community, in keeping with its preventive orientation, its stress is on detection in the *early* stages of disturbance where therapeutic intervention can have a greater impact.

Such early detection is facilitated by a number of factors. First, the location of the dispensary and its specialized functions are generally well known. Also, service is at no cost to the patient and waiting lists do not exist. Any person within the dispensary's territorial jurisdiction is eligible for and may request service.

While it was reported to the delegation that most patients are identified in this informal manner, there are other routes to the dispensary as well: Referral may be made from any of the previously outlined facilities, though admission to the dispensary is not limited to these sources. The key to the dispensary's effectiveness is its liaison with a wide variety of public agencies.

The NP dispensary, for example, is responsible for providing all follow-up care and treatment of patients released from the mental hospital. Within twenty-four hours of discharge, the dispensary is notified and the patient's records forwarded. Within ten days, the patient is expected to visit the dispensary and should he fail to do so, he will be visited at home by either the dispensary nurse or psychiatrist assigned to his district.

In the case of the dispensary patient referred to the mental hospital, continuity of care is also maintained through staff communication. The dispensary psychiatrist, for example, may regularly attend and participate in the hospital staff conferences regarding the patient.

МЕДИЦИНСКАЯ
ПОМОЩЬ
НА ДОМУ

Russian psychiatrists make regular home visits. Lettering on car reads "Medical Aid to the Home."

Regardless of the route by which the patient reaches the dispensary, his initial contact results in his being registered. This regulation—which consists of recording data such as diagnosis and relevant administrative procedures—becomes the enabling mechanism for maintaining continuity of care.

The System of Dispensary Registration

When all the appropriate data are collected, the patient's records are placed in the general file covering his home region. All the records for that area—and for each area served by the dispensary—are divided into five groups.

The first of these groups includes patients who have been released from the mental hospital within the past months. These patients are in the dispensary's "high priority" group for home visit and observation.

The second group of patients includes those who have not been recently hospitalized but who are subject to frequent, acute psychotic episodes; those in need of therapeutic after-care, or those patients who are viewed as a potential threat to society.

Group III consists of chronic cases who are not in need of hospitalization, but who are regarded by the dispensary staff as not having made an adequate social recovery.

The patients in Group IV do not receive regular or active treatment, though they do remain under observation. They are typically patients who are in remission after a psychotic episode or those who display mild mental disorder as a result of organic brain damage. Placement in this group is contingent on the patient's demonstrating an adequate social adjustment.

Group V includes those patients who are currently hospitalized.

All patients' records are reviewed at least once every three months. There is considerable flexibility in placement, and records will readily be shifted to another category should the patient's condition warrant it. Although all patients remain under continuous review, it is possible for patients to have their names removed from the registry. While this may be accomplished in an informal sense by, for example, the patient moving to an area served by another dispensary, actual "delisting" is at the discretion of the dispensary staff. It is based on the "genuineness" of the patient's recovery, understood by the delegation to mean that the patient was able to return to work and did not pose a threat to society. Even under these circumstances, however, the patient must first remain under observation for a period of from one to five years depending on his initial diagnosis. Therefore, once the psychiatric patient is registered, he no longer retains the same freedom of choice concerning treatment accorded the general medical patient.

Once registered, decisions regarding initiation, frequency and duration of treatment appear to become the prerogative of the NP dispensary staff. In the case of what in the United States might be termed the "resistive" or "unmotivated" patient, vigorous follow-up through home treatment can take the place of dispensary visits.

With regard to record-keeping, the delegation noted that all monitoring and review was done manually. There was no evidence of the application of computer technology in the compilation, coordination or sorting of records. Despite the extensiveness of individual medical records, there was little attempt to compile statistics beyond the agency level. Although a remarkable opportunity exists for an extensive statistical compilation, there seemed to be no national epidemiological data available in the Soviet Union.

Psychiatric Treatments at the NP Dispensary

To achieve social recovery for patients, there is a variety of treatment modalities available, but they may be grouped under the general categories of chemotherapy, ergo- or work therapy and the Russian interpretations of psychotherapy.

Chemotherapy in particular seems heavily utilized. A majority of the patients observed at the dispensaries were on various psychotropic drugs and the dosages appeared to be somewhat higher than those usually employed in the United States. Patients, however, did not appear to be over-sedated and the delegation was told that attempts were made to balance stimulants and tranquilizers.

Each dispensary includes a workshop for the practice of work therapy. Inasmuch as the workshops are found outside of dispensaries as well as within them and are an integral part of the psychiatric network, they will be discussed independently. At the dispensary, however, workshops often appear to fill the functions of a day hospital unit. Although the Russians claim the dispensaries do provide day hospitalization, the delegation noted that very few dispensaries had specific units for this purpose.

Psychotherapy, as practiced in the Soviet Union, encompasses a variety of approaches, including highly directive individual and group discussions; hypnotherapy and other suggestive techniques; relaxation; and behavior con-

The workshop building at a Moscow NP Dispensary.

ditioning. While there is less heterogeneity than in the United States—there are for example, no psychoanalysts—it was the delegation's impression that there was considerable variability in practice and orientation in different parts of the Soviet Union.

In the Leningrad area for example, the delegation observed group discussions that were very similar—in both content and style—to what might be observed in group therapy sessions in the United States. The practice of psychotherapy in Leningrad, however, is the *least* directive of Russian psychiatry, and in Moscow, group therapy could well be described as the group application of hypnotherapy, suggestion, or relaxation techniques.

In general, it was the delegation's impression that the therapist was accustomed to playing a far more active and directive role than is common in the United States. The giving of specific advice, direction, and guidance are clearly accepted therapeutic techniques. At the same time, the delegation noted numerous examples of sensitive, warm interest on the part of the therapist toward the patient, and we were very much impressed by the concern for the individual patient that came to characterize, for us, the essence of Russian psychiatric treatment.

Consultation and Preventive Education

Consultation and preventive education programs are not particularly easy to delineate inasmuch as they are ingrained in the day to day operation of the dispensary. Thus, for example, while there does not appear to be a formal "theory" of consultation, there is a wide variety of "consultative" contact between staff of the dispensary and numerous other elements of the psychiatric and medical networks.

Mental health education is similarly a basic element in the dispensary's operation. Generally, it falls under one of three categories—education for the general population, education for those with mental disorder and education for the non-psychiatrically trained physician.

Through a combination of consultation, lectures and talks, and didactic material, it is apparently felt that early detection and treatment of mental disorder can be facilitated by all health professionals. What should be stressed is the delegation's impression that these activities were regarded as a worthwhile and, indeed, essential component of the dispensary's operation, fully worthy of the professional staff's attention.

New patients enter Kaschenko Hospital at this receiving building.

MENTAL HOSPITALS

It was striking to the delegation to note the vigorous enthusiasm expressed by health officials and professional personnel regarding the mental hospitals. In the Soviet Union, the mental hospital occupies a particularly prestigious position. It is here that many of the Chairs of Psychiatry are located and it is at the mental hospital that a large part of the specialized psychiatric training takes place.

The mental hospital is the specialized unit providing inpatient care within the network of psychiatric services. As with other medical facilities, the mental hospitals are distributed on a regional basis and they supplement and work in close collaboration with the neuropsychiatric dispensaries.

Part of the status in which the mental hospital is held springs from the fact that the Russians have never felt there was a sufficient number of them. The second World War resulted in massive destruction of Russian hospitals; and, as a result, the development of a preventively oriented outpatient care framework was as much a matter of necessity as of conviction.

This is reflected in the fact that the highly coordinated continuity of care network developed by the Russians has not resulted in any reduction of hospital admissions. The Russians continue to press for the construction of mental hospitals and the addition of psychiatric beds, for they regard the mental hospital as a powerful and effective treatment resource. The spirit of optimism characterizing Russian psychiatry is nowhere better reflected than at the mental hospital, and there is little difficulty in attracting highly qualified and devoted staff, especially in the urban areas.

A psychiatrist talks to a geriatrics patient at a Home for Invalids.

The mental hospital is conceived of as a facility which provides inpatient treatment for people when they need it, as they need it. Little concern is apparently given to rates of admission or average length of stay of patients. There are other resources in the community designed to support and maintain the psychiatric patient and every effort is made to discharge the patient as soon as is reasonably possible, thereby making scarce psychiatric beds available. This framework is particularly well illustrated by the statistics reported by Kaschenko hospital. Kaschenko—a 2,600-bed unit in Moscow—treated over 16,000 patients a year—utilizing each psychiatric bed during the year for approximately six patients.

It is important in this regard to note the Russians' attitude toward subse-

A ward building at Kaschenko Hospital.

A ward for disturbed patients.

quent or numerous admissions for individual patients. The Russians think of mental illnesses—especially the major ones—as potentially recurring disorders. When such recurrence makes hospitalization necessary, it is viewed as a matter of course. Every effort is made to control the episode and, that accomplished, to discharge the patient.

This attitude was well-summed up by a physician at the Kaschenko hospital. "We think," he stated, "we can get most patients—even chronics, out of here in less than two months, through the use of drugs, small doses of directive psychological therapy and large doses of physical activity. We realize that many of them will come back—this does not bother us. Every day they spend in the community is a gain for them and for our nation. But they have a disability and from time to time they may require supportive treatment just as a cancer or heart patient does."

The critical element in the system that enables this attitude to be translated into practice rests with the network of follow-up care facilities, through which continuing and appropriate treatment of the patient is assured, as needed.

One of the more striking features of the Russian mental hospital is the unusually high patient-staff ratios. This is all the more impressive in view of the worn-down, dilapidated condition of most of the hospital buildings. Considering their condition, it is hard—at least initially—to anticipate the vigor and enthusiasm of their staffs and treatment programs.

At Kaschenko, for example, there were 160 psychiatrists for the 2,600 beds—a 1-to-16 ratio. Additionally, there were more than 800 nurses. At the Vinnitsa

Dr. H. C. Masliaeva, Deputy Director, and Dr. B. M. Morkovkin, Director, in a Kaschenko Hospital dining room.

A patients' dining hall at Kaschenko.

A typical ward in a mental hospital.

Mental Hospital with 1,900 patients, there were more than 100 physicians of whom 87 were psychiatrists; more than 450 nurses and over 700 ward orderlies. Overall, the patient-staff ratios were virtually 1 : 1.

In some of the rural areas, the ratios are not reported to be as high, but they remain impressive by American standards. At the Ramenskoy hospital, a rural facility for some 100 chronic patients, the delegation noted only three physicians, but even here there were 25 nurses and 35 ward aides.

Mental Hospital Staffing Requirements—Regulation #805

The plethora of professional staff in the Russian mental hospital is achieved by design and sanctioned through official regulation. Last revised in 1952, and currently under study, regulation #805 provides standards for the staffing of various wards in the psychiatric hospital.

Current standards are as follows:

Pediatric Departments and General Hospital Psychiatric Units

1 psychiatrist to 25 patients
1 nurse to 30 patients

Psychiatric Hospital

Acute and disturbed units
1 psychiatrist to 25 patients
1 nurse to 30 patients
1 orderly to 15–20 patients

Forensic Unit
1 psychiatrist to 25 patients
1 nurse to 20 patients
1 orderly to 12–13 patients

Quiet wards, not disturbed
1 psychiatrist to 30 patients
1 nurse to 30 patients

Chronic wards, disturbed
1 psychiatrist to 50 patients
1 nurse to 40 patients
1 orderly to 20–25 patients

Chronic wards, quiet patients
1 psychiatrist to 80–100 patients
1 nurse to 70 patients
1 orderly to 30–35 patients

In addition, each unit is assigned a chief physician who has responsibility for patient care; a chief nurse; an administrative nurse and a medication nurse. Each hospital work shift must have the same proportion of staff. There are additional personnel, such as physical therapists, laboratory workers, and dieticians.

It was reported that most hospital staffs are larger than the minimum standard, and that special projects such as alcoholism programs, postgraduate training and research, and workshops, are authorized to have additional personnel.

Recently, because of rehabilitation requirements for chronic diseases, some mixing of patients has occurred, leading to a review of standards. It was the delegation's understanding that new requirements were being developed for staffing children's facilities, alcoholism programs and geriatric wards.

Admissions to the Mental Hospital

With regard to procedures for admissions, the delegation was told that the psychiatric units in general hospitals would accept only voluntary patients. The mental hospitals will accept voluntary patients and, without commitment, the patient who opposes admission *if* his family or other community agent approves. Ninety-five percent of all admissions to the mental hospitals

Architectural styles vary at Kaschenko Hospital ward buildings.

are classified as voluntary. It must be remembered, however, that this category includes cases where there is family consent, but patient opposition.

The route to the mental hospital usually starts at the NP dispensary. It is significant to note that only a psychiatrist—not a general physician—can certify a patient for psychiatric hospitalization. On admission to the hospital, the patient is given a second examination at the admitting unit. If the examining psychiatrist feels the patient's illness does not warrant hospitalization, he will not be admitted. A third step in the admissions procedure may take place at the ward to which the patient is assigned. The ward psychiatrist must also concur in the judgment that hospitalization is necessary; if not, the patient will be released.

Number of Psychiatric Beds

There is no clear-cut figure on the number of psychiatric beds in the Soviet Union. Although there are reported to be 225,000 beds under the jurisdiction of the Ministry of Health—primarily in the mental hospitals and neuropsychiatric dispensaries—there are numerous other facilities that handle psychiatric populations.

There are, for example, roughly 125,000 beds in the Homes for Invalids, under the jurisdiction of the Ministry of Social Welfare. While the delegation was unable to obtain any clear-cut information on the diagnostic classification of patients occupying these beds, it was our impression—based on visits to several of these facilities—that psychiatric patients were included.

In addition to the Homes for Invalids, facilities for the care of psychiatric populations include the sanitaria for neurotics. The delegation, however, was unable to obtain statistics on the number of beds available in these facilities. These sanitaria are operated by the local trade unions and are independent of any national Ministry.

In summary, then, it was the delegation's conclusion that the number of beds devoted to the care of psychiatric patients exceeded the 225,000 available under the jurisdiction of the Ministry of Health. The true number of such beds, however, could not be ascertained.

In any case, it is difficult to make a comparison between estimates of the number of Russian psychiatric beds and the approximately 690,000 psychiatric beds available in the United States. As stated earlier, the Russians have never felt they have had a sufficient number of psychiatric beds. For years, these comprised only ten to fifteen percent of the total number of hospital beds, and the construction of new mental hospitals remains a stated priority.

In the United States, however, we are decreasing the number of mental hospitals and supplementing them with service programs designed to reduce the need for hospitalization, notably the community mental health centers. At some point in the foreseeable future, the Russian emphasis on expanding the number of psychiatric beds and our emphasis on reducing the number should lead to roughly equivalent hospital bed ratios per thousand population. (Mental hospital treatment programs are discussed in Part III)

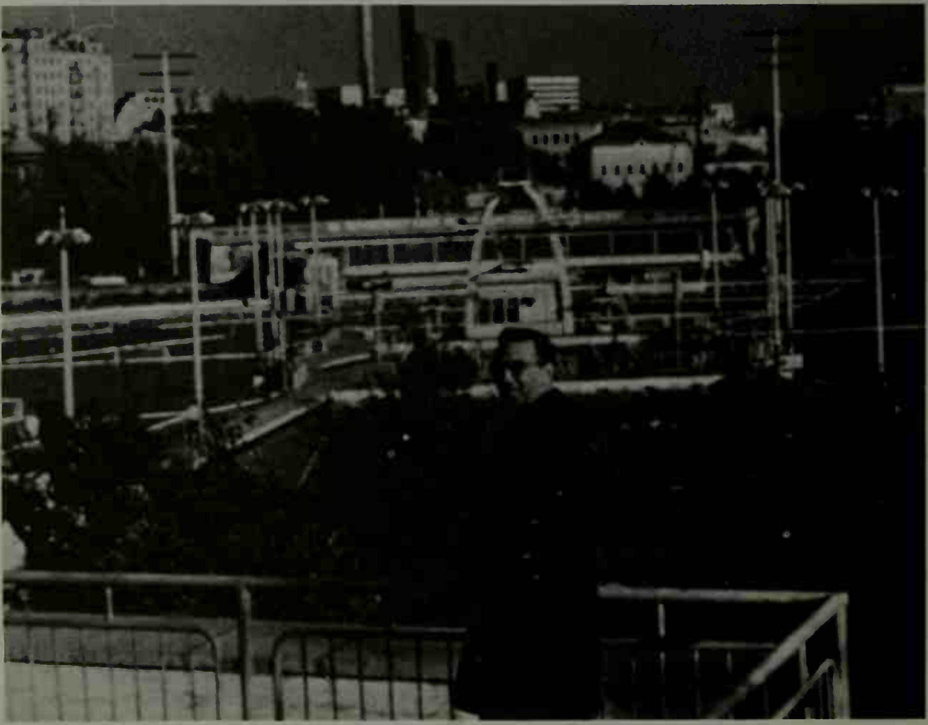
Members of the delegation at Kaschenko Mental Hospital, with the Deputy Director and Director, Moscow.

GENERAL HOSPITALS AND PSYCHIATRIC SERVICES

Just as the mental hospital in Russia is the central facility for hospital treatment of psychiatric disorder, the general hospital is the focal point for hospitalization of physical illness in the Soviet Union; but the relationships between the two systems are quite different from those in the United States. The contrast is particularly striking; first, in terms of the way in which general medical services are provided for hospitalized mental patients; and second, in the attitudes of general hospitals toward the treatment of mental illness.

The delegation, for example, saw no medical or surgical buildings, or infirmary wards with specialized care facilities for the physically ill patient confined to bed in a mental hospital. We were told that when a psychiatric patient was in need of medical treatment, he could be transferred to a general hospital, or that consultants from the general hospital or other medical facility were available to the mental hospital staff. In the United States, many mental hospitals have complete facilities for physical medicine and surgery. This is not the case in the Soviet Union and the delegation felt that this lack might tend to delay physical treatment of patients, since the psychiatrist in attendance may not apply appropriate medical therapies at the earliest moment of need.

The Russians, however, apparently do not share this view and feel that since the general hospitals and the mental hospitals are all administered



Dr. Sirotkin—outdoor swimming pool in Moscow.

by the Ministry of Health and are located in the same regions, that patient referral between the two types of facilities can be routinely arranged.

The difference between stated plans and practice—in the relationships between the psychiatric system and the general medical system—became evident as the delegation sought to secure information about the development of psychiatric wards within general hospitals.

Although we heard much during briefings and visits about Soviet plans to establish new psychiatric services in general hospitals, the delegation saw few operating examples. It was our impression that the units which did exist were more a branch of the department of internal medicine than of psychiatry.

We persisted in our questions, however, since the development of psychiatric services within general hospitals in the United States has served in recent years to improve the quality and continuity of care of mental patients and we hoped to learn more of our Russian colleagues' attitudes toward a similar development in their country.

Mike Gorman taking notes while overlooking the Moscow skyline.

The delegation eventually decided that part of the resistance to the establishment of psychiatric services in general hospitals came from differing administrative points of view. Although the Ministry of Health is the directing agency for the hospital system nationally, we were told that general hospitals in Russia are directed by the local, or regional, ministry of health and that these local authorities operate under a degree of autonomy within their own jurisdiction which makes it possible for them to adapt or reject some of the programs espoused by the national Ministry of Health.

At any rate and for whatever reasons, the delegation's general consensus was that the Russian effort to treat psychiatric patients in general hospitals was modest and that existing examples illustrated a quite conservative approach to such a treatment program.

General hospitals, when they did include psychiatric departments, seemed

Gardens and social pavilion at Kalinovka General Hospital.

Judge Bazelon, with camera, and Dr. Yolles taking in the sights.

to admit only those patients who could be easily treated and managed—largely the psychosomatic case, the mild neurotic, the epileptic, the less severe cases of alcoholism, or of mental retardation.

Although the Russians repeatedly indicated that they needed more psychiatric beds, the general hospital beds were clearly not considered to be substitutes for, or additions to, the mental hospital beds. An acute schizophrenic, for example, seeking admission to the general hospital would be quickly transferred to the appropriate mental hospital.

It was evident that, although there exists a limited effort to effect a closer liaison between hospital treatment of psychiatric and somatic illness, the proposed development has not as yet received general support. The general tenor of psychiatric and medical opinion in the Soviet Union is that psychiatric patients in need of hospitalization can best be managed and treated in small, specialized, wholly psychiatric facilities, or through consultative procedures.

HOSPITAL FOR BORDERLINE PATIENTS

Although the Russian health care system is nationally organized and completely controlled by the State, its planning mechanisms—at least in some instances—have a flexibility which makes it possible to mount a selective attack on specific disease entities.

The hospital for borderline patients in Moscow, which concentrates its entire effort on the treatment of neurotics, is a dynamic example of this ability. The hospital was the only one of its kind in Moscow; the Pavlov Institute for the Neuroses in Leningrad is a similar facility. The delegation secured no additional information on the number and distribution of these hospitals in other parts of the Soviet Union, but we were impressed by the one example we observed.

Handling 4,000 admissions a year in the four hundred bed facility, the hospital for borderline patients has developed an exceptionally large staff to provide highly intensive treatment for patients with mild neuroses, depression and the not too clearly-defined character disorders. Agitated patients are

Volleyball provides recreation for neurotic patients.

not accepted for admission and the most common diagnostic groups were reported to be the obsessional states and depressions.

Patients may be referred from the neuropsychiatric dispensaries and in some cases from the psychiatric units of general hospitals, but such referrals are not necessarily required. Any individual may voluntarily request admission for treatment.

The hospital provides short-term, intensive therapy; there are no locked wards and the delegation did not note any of the workshops so characteristically a part of most Russian psychiatric facilities.

Of all the institutions visited by the delegation, this one provided the most eclectic range of therapies. The therapeutic emphasis appeared to be on Moscow-oriented psychotherapy, including group therapy, hypnotherapy, psychodrama, and several kinds of behavioral conditioning.

Patients outside the main ward building of the Hospital for Borderline Patients.

Most patients are reported to stay for an average of from thirty to forty days, after which they are referred to the neuropsychiatric dispensary for follow-up care.

The most impressive feature of the organization was the staff assembled to provide this short-term, intensive treatment. At the Moscow facility, there are 31 physicians—of whom 21 are psychiatrists—287 nurses, 182 aides and ward orderlies, for a patient population of 400. The staff, therefore, outnumbered the patients. There is no public institution comparable to this in the United States.

WORKSHOPS

The Workshop is the ubiquitous establishment of the Russian psychiatric network. Found in all mental hospitals, neuropsychiatric dispensaries and even some Homes for Invalids, these shops reflect the Soviet emphasis on work as both a therapeutic and socially productive activity.

Although much of the work performed in psychiatric settings is crude—assembling boxes, gluing envelopes, making string shopping bags—the range of activity is wide and there is opportunity to perform highly technical work as well. Some workshops have electronic equipment and many of the instruments in hospital use—electrocardiograms, electric-shock apparatus and the like—are also produced in workshops.

While the emphasis is on rehabilitation and job retraining, patients are not forced to participate in activities. In their visits to workshops, the delegation saw many patients sitting quietly, or moving from activity to activity. Throughout, they were gently encouraged by the staff and the already working patients.

The workshop is unique in a number of respects. First, the patients are paid for their labor. Work is a respected, indeed, exalted activity in the Soviet Union, and the financial rewards convey to the patient that he is performing a worthwhile endeavor. These financial arrangements are possible since the materials produced by the workshop—even the string shopping bags—are the result of an exclusive contract between the workshop and some outside agency or industry.

Workers who are inpatients at a hospital receive 30 percent of their earnings, with the remaining 70 percent being used by the hospital to finance recreational activities, cultural visits, building construction and equipment. Outpatient workers at the dispensaries are paid their entire earnings in addition to receiving two meals a day.

Most of the workshops are directed by a psychiatrist who, in conjunction

The workshop building at Vinnitsa.

with an economist and rehabilitation expert or engineer, plans the workshop program in accordance with the various contracts. Although the workshop has a profit-making, job-training function, it is essentially a therapeutic and rehabilitative facility. In addition to the various opportunities for productive work, the delegation noted patients in recreational activities such as billiard playing or painting. Although the emphasis was on keeping the patient "vertical" and active, most workshops had beds where patients could rest if they so chose.

Perhaps the most striking element in the workshop program was the positive attitude conveyed to the workshop-patient. Despite the fact that the patients had impairments of varying degrees of severity, they were being

Sewing rooms are typical centers of work therapy in mental hospitals.

Highly skilled patients construct electronic equipment.

treated as people with substantial resources, able to perform meaningful activity and in many cases, to learn new skills. At whatever level they were able to perform, their contribution was regarded as worthwhile, backed up with financial reward.

It would be impossible to overemphasize the importance of the concept of work in the Soviet society and of ergo-therapy in Soviet treatment of psychiatric patients. The workshops in psychiatric facilities are special working organizations under constant supervision of the medical staff, psychiatrists and instructors especially trained for this assignment.

Work is considered to be the foundation upon which the social readaptation of mental patients is based. As authorities have pointed out, there are no social clubs to occupy the leisure time of these patients; no charitable institutions are organized on their behalf and no organizations of volunteers who wish to help the mentally ill. The "citizen volunteer" who serves as an advocate for the mentally ill does not exist in the Soviet Union.

In explaining their philosophy toward work as therapy, the Russians point out that, although psychotherapy is used, they do not concentrate on therapy by words, but rather on therapy through work in a group. In doing so, the stated purpose is to incite the patient to action and to help him organize an activity that will be useful to society. Freud's psychoanalytic method is not practiced by the Soviet psychiatrists.

Patients weave baskets at Vinnitsa Mental Hospital.

The result of this concept has not only focused the patients' attitudes on work as the road to recovery; it has caused Soviet psychiatrists to develop a clinical theory of the prognosis of work capacity among the mentally ill. In the U.S.S.R. there are several scientific centers that carry out research on the problems of psychiatric rehabilitation and medical assessment of the capacity for work. Through these studies, Soviet medical experts and social psychiatrists say that they hope to establish a basis for further expansion of activities, not only to accelerate the social adaptation of the physically disabled and of mental patients, but also to prevent disability.

Patient Services for Special Groups

ALCOHOLISM AND DRUG ABUSE

The Russian attitude toward alcoholism is interestingly ambivalent. For years, the Soviet denied that the problem of alcoholism existed in their country; a few years ago, the medical profession began to discuss alcoholism as a problem; they now state publicly that alcoholism is a major social problem, and wherever the delegation went in Russia, we were asked about our techniques, practice and therapy in controlling the misuse of alcohol. Unfortunately, in both Russia and the United States, no generally satisfactory treatment of alcoholism has been evolved, but the current Russian attitudes toward and treatment of alcoholics constitute a major attack on the problem.

In the Soviet Union, drunkenness, per se, is not a crime. Alcoholism is considered to be a disease and is treated as a mental illness. Even so, it is interesting to note that alcoholism may not be used as a defense in cases where criminal activity occurred while the individual was under the influence of alcohol. The Russian attitude toward legal responsibility of the alcoholic is very stringent, whereas, as regards treatment, the attitude is strongly medical.

When a drunk is picked up by the police, he is taken to jail, but he is not put in a jail cell. Jails in Russian cities have separate units—called "sobering-up stations." The units are staffed by a doctor, aided either by a feldsher or a nurse. Because of this program, a drunken individual receives immediate treatment by a doctor. If he needs hospitalization, he is immediately hospitalized. If he does not, he spends the night at the sobering-up station and is driven home in the morning by a policeman. This treatment, however, unlike other medical services in the Soviet Union, is not free; the drunken person or his family pays the cost. However, if an alcoholic is sent to the hospital, he participates, like any other patient, in the hospital regimen. Activity in the hospital workshop is regarded as a particularly important aspect of the alcoholic's restorative treatment. In addition to the pay the patient receives for his work, he is, in the Russian view, made to feel a responsible and productive member of society. But if he is picked up for an overnight stay in the "sobering-up station" both his employer and his family are notified of the episode.

So concerned are the Russians about the misuse of alcohol—especially among young people—that a law was adopted in September, 1967, requiring that all alcoholics must take treatment. At the same time, however, the delegation noted that the Russian society—from medical personnel to a man's fellow workers—will go to great lengths to keep an alcoholic from losing his job. A man's work, in Russia, is a central part of his identity and the treatment of an alcoholic is designed to protect him, whenever possible.

Dr. G. V. Zenevitch heads the Alcohol Section of the Bekhterev Psychoneurological Research Institute, Leningrad.

When our delegation visited the alcoholic service of a neuropsychiatric dispensary in Moscow, we were told that there were 2,800 alcoholics listed in the records—close to 25 percent of the dispensary's total patient load.

As part of its treatment campaign, each NP dispensary staff includes a narcologist. As a psychiatrist specializing in the treatment of alcoholism, he is responsible for prescribing treatment, which is often prescription of antibuse, atromorphine, or other aversive therapies. A wide variety of neuroleptics are employed and the Russians seem quite sophisticated in their use. Trifluoperazine is used particularly in the treatment of alcoholic hallucinations; tranquilizers are employed in the treatment of delirium tremens, otherwise known in Russia as "white fever." Additionally, benactyzine and chloriazepoxide are extensively used.

Although there has been considerable reliance on the treatment of alcoholism through drugs, the Russians feel that they have made little progress through such methods and they are stressing other approaches, particularly

Group therapy is used in treatment of alcoholism.

behavior therapies and preventive education. They have evolved a group psychotherapy method for the treatment of alcoholics which differs from methods used in the Western world where therapy is mainly based on psychoanalytic principles.

In the Soviet Union, group therapy in the treatment of alcoholics may include hypnosis, or a therapy in which positive suggestion is used in a manner similar to its use in hypnosis. The patients are told to relax, and are then told by the therapist how they will think.

In discussions of treatment, we were informed that the Russians believe the principle of successive stages is one of the major factors determining the success of treatment. Treatment is divided into three stages. During the first stage, the narcologist works to eradicate such symptoms as insomnia, lack of appetite, moodiness, and physical weakness. In so doing, the therapist hopes to win the patient's trust and strengthen his conviction that treatment can be successful. The goal of the second stage is to overcome the desire to drink, and that of the third state is to stabilize the results of the preceding treatments.

To achieve this, and to prevent relapses, the Russians have mounted a concentrated program of public education. Doctors and psychiatrists from polyclinics and NP dispensaries visit factories once a week to lecture on the evils of alcoholism. They also visit apartment houses, where all the residents are assembled to hear a talk by a medical authority. In factories and elsewhere one sees posters designed to support efforts to control alcoholism. Simultaneously, Russian research in psychopharmacology and the utilization of psychotropic drugs continues, as Soviet investigators, like their American counterparts, seek the methods to control and eventually to prevent alcoholism by whatever means are found to be effective.

So, although the Russians have not solved the problem of alcoholism, the delegation was impressed with the framework for the treatment of alcoholics. It is firmly rooted in the health care system and aggressive efforts are made to provide medical and humane treatment and rehabilitation for the alcoholic.

Drug Abuse

The delegation became aware, during our discussions and observations of the alcohol problem, that the narcologists were unconcerned with drug abuse and that the misuse of drugs in Russia simply does not exist as it does in the United States.

In certain parts of the vastness of Russia, there are civilizations in which the use of drugs has been endemic for centuries, but in the republics of Russia proper and in Russian cities, there are no hippies, or young people turned on by LSD, or assembled for "pot parties." The Soviet culture is not permissive when it comes to the use of drugs. Its attitudes toward drinking may be ambivalent. Certainly, one sees many drunken young people in Russia, but the kind of drug use current in America is not as yet, at least, a Russian phenomenon. Whether this is the result of the strong, punitive legal deterrent to the use of heroin and other drugs is a matter for discussion; certainly these deterrents are a factor in conditioning public attitudes against drug abuse.

CHRONIC PATIENTS

The care and treatment of the chronic mental patient reflects a curious ambivalence in the Russian attitude toward chronicity. Given the Russian framework of a highly coordinated network of linked facilities providing constant support and maintenance of the patient, it would seem that the problem of 24-hour, institutional care for the chronic patient should almost disappear. At times, variations of this attitude were directly expressed to the delegation. As one physician—the director of a mental hospital that had recently been transformed from a facility for chronic patients and with a still substantial chronic population—put it, "I do not believe in chronicity. Much of the chronicity in this hospital has been inherited—it is the result of years of custody. I intend to devote the rest of my life fighting the dragon of chronicity."

Such forceful optimism notwithstanding, chronic mental patients—in the Russian classification "psycho-chronics"—do exist and the delegation noted that a substantial number of these are cared for outside the "mainstream" of medical practice in specialized facilities for chronics.

These Homes for Invalids, operated under the jurisdiction of the Ministry of Social Welfare rather than the Ministry of Health, seem quite content to aim at—and to provide—a high level of custodial care.

It should be pointed out that the delegation experienced considerable difficulty in getting to visit the various facilities for chronic patients. Inasmuch as the responsibility for the care of chronic patients is divided between two Ministries, some of the difficulty was initially attributed to untangling the knot of Russian bureaucracy. Additionally, however, it seemed our Russian hosts were genuinely embarrassed by the dilapidated condition of many of the buildings housing chronic patients, and on a few occasions the delegation was asked not to take any photographs of the facilities visited.

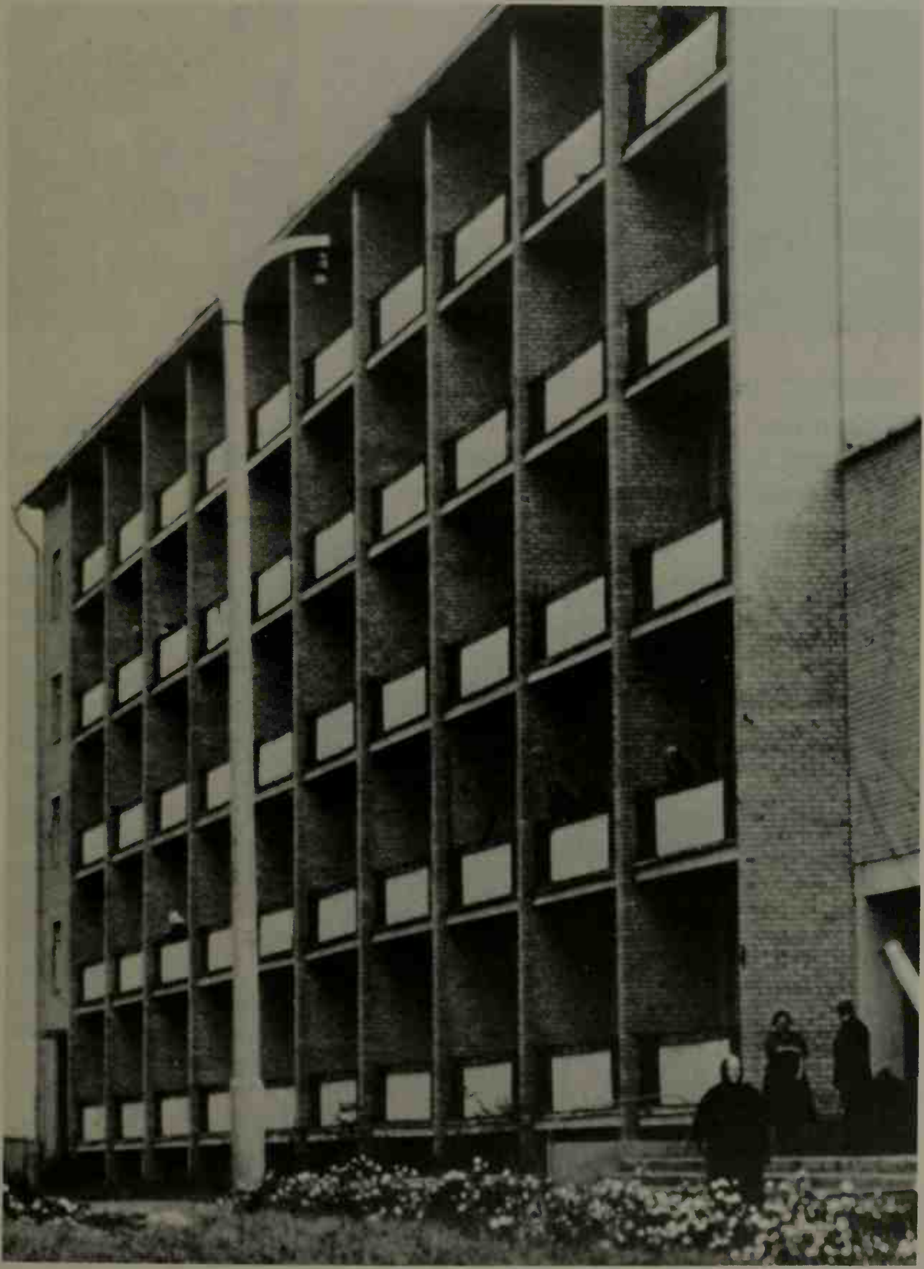
Further, the organization of the care and treatment of chronics is currently in a stage of transition. At one time, the Soviet Union had a network of what were termed Work Colonies which housed a population of the chronic, aged and infirm. With the introduction of drugs and the expansion of the psychiatric service system, these facilities are in the process of being phased out. Patients who ordinarily would have been sent to the Work Colonies, it was reported, were now largely able to be maintained in the community, with some being transferred to the Homes for Invalids.

Despite their reticence, however, it was the delegation's impression that in regard to their care of chronic patients, the Russians had little to be ashamed of.

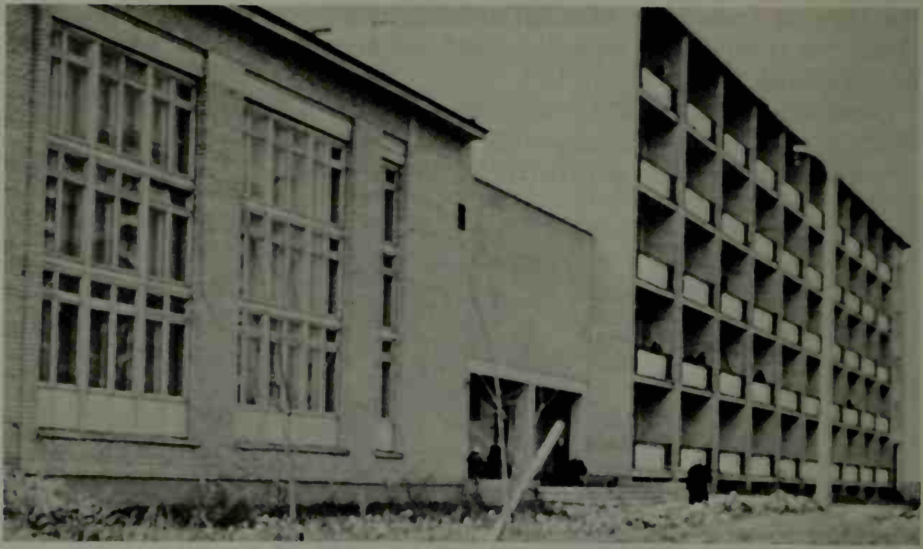
Programs for the chronic mental patient—whether in the medical or welfare system—spring from the basic philosophy that aims at keeping the patient "vertical," or ambulatory. While there seems to be a greater emphasis on "rehabilitation" and a greater aversion to custodial management in the Health Ministry than in the Welfare Ministry, in both systems every effort is made to ensure that all patients—even severely impaired ones—will get as much out of life as possible.

Thus, it was striking to the delegation—but thoroughly in keeping with the Russian framework—to find husbands and wives living together in a Home for Invalids and indeed, a scheduled marriage between two patients in their seventies.

Considering the difficulties encountered by the delegation in visiting the facilities for chronics—we never did see a facility devoted solely to the care of psycho-chronics—we were particularly interested in the routes by which a



A Home for Invalids, Moscow, where chronic patients receive treatment.



The theater wing, Home for Invalids, Moscow.

patient reached the specialized chronic installations.

In the Russian view, chronicity does not refer solely to the recurrence of symptomatology. In fact, mental illness is regarded as a disorder where relapses may be expected to be frequent and rehospitalization a routine, necessary procedure.

A more critical element in the determination of "chronicity"—and thus, the path the patient takes—is the capacity for "social readaptation," measured in large part by the patient's ability to work.

This concern with work and productivity pervades the Russian psychiatric network and every psychiatric patient is rated on a five-point scale as to his employability. Employers are required to place mental patients at their former jobs, at former salaries, if they are adjudged to be mentally fit. In a case where the patient is no longer able to hold his previous job, the employer will be requested to provide suitable employment—either full or part-time—consistent with medical recommendations. Any loss in salary resulting to the patient from such occupational shift will be compensated for by a pension from the Ministry of Social Welfare, and these pensions will continue for the duration of the incapacity.

For those patients unable to work, a number of alternatives exist. The neuropsychiatric dispensary, through home visits, is able to maintain contact with those patients living at home. For those patients without families a system of foster care is maintained.

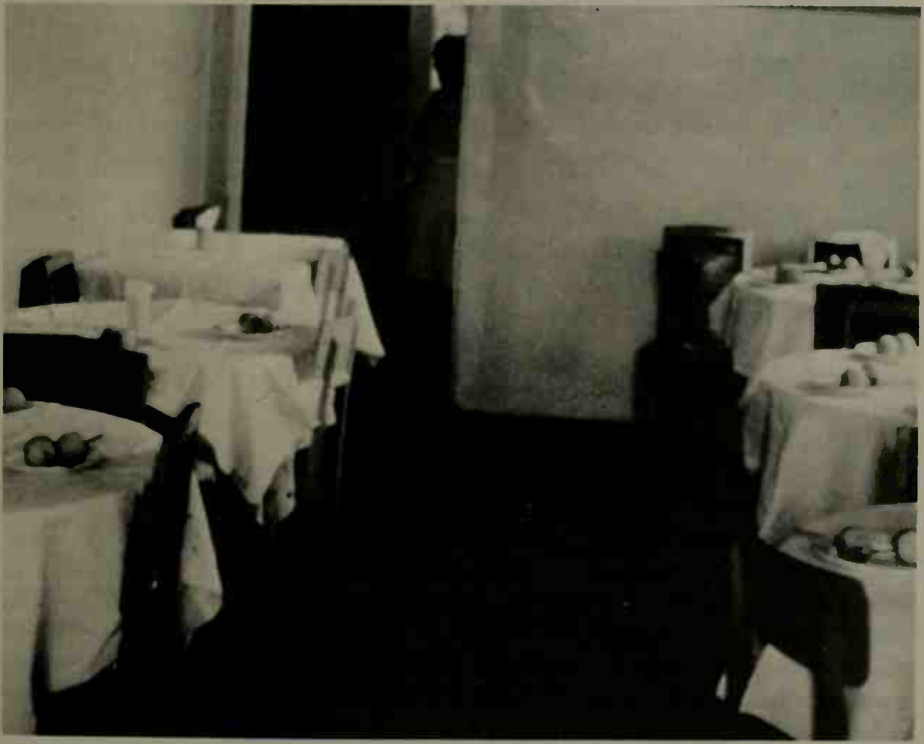
Inpatient care at a mental hospital or Home for Invalids is also possible and it was reported to the delegation that from ten to fifteen percent of the severely mentally disabled were institutionalized. As has been indicated earlier, however, placement at these facilities is not equivalent. At least in theory, the Home for Invalids provides care for manageable, ambulatory patients who are not in need of the specialized services of a psychiatric hospital. The population of these essentially welfare-based facilities was reported to be largely senile psychotics and other "non-recoverable" mental patients as well as individuals with advanced arteriosclerosis, Pick's disease and so on. Most of the population of the Home for Invalids are apparently individuals without family ties, or patients whose home environment is regarded as inadequate for proper care. There do not appear to be any clear-cut criteria as to when guardianship, for example, is to be preferred to placement in a Home for Invalids, and it may be concluded that placement in the various facilities for chronics is largely a judgmental matter based on medical recommendation.

Despite the questions the delegation had regarding the wisdom of dividing the care of chronic mental patients between two Ministries, our overall impression was decidedly favorable. As with other elements of the care network, a major emphasis of the specialized chronic facilities lay in preservation and maintenance of human dignity. In that regard, the Russian attempt to care for chronic patients was notable.

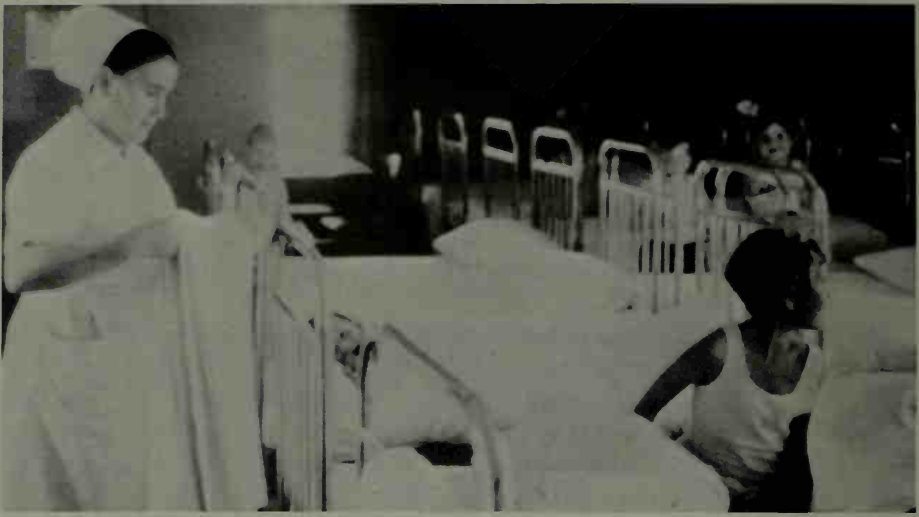
CHILDREN'S SERVICES

Not long after the delegation had arrived in the U.S.S.R. one of the interpreters commented, "The Russian people love their children inordinately. Even the worst hooligan will come to the aid of a child who is crying."

In actuality, care of the child begins before he cries, on an intensive and



Moscow Children's Hospital dining hall.



A children's ward.

meticulous basis, with the pregnant mother. From the fifth month of pregnancy, there is the beginning of an accumulation of a vast amount of physiological data on the child yet to be born. Obstetricians and pediatricians visit the homes of all pregnant women on a regularly scheduled basis.

When the mother delivers the child, the children's polyclinic is immediately notified by the hospital. From that time until the child reaches the age of 16, the polyclinic is the medical hub of all health services designed to meet the special needs of children. All the families in the neighborhood know where it is located—no one needs to look up the number in the phone book—since there is a children's polyclinic in each district of approximately 40,000 people.

There is nothing haphazard about the guidelines for the care of a child in the U.S.S.R. Certain standards are established and must be met. For example, as soon as the mother returns home from the hospital, the doctor and the nurse must visit her and give her a regimen for the newborn infant. During the first month of a baby's life, the physician must call five times at the home, and medical data on these visits must be recorded in the polyclinic files. Until a child is two to three years of age, the physician is required to see him at least once a month, and continues to see him at least every two or three months until he enters kindergarten, when the school medical unit assumes liaison responsibility with the child and the polyclinic.

The organization of health services in Russia is complete and health services for children bear this out. The health services program for children is separate from adult programs and this specialized child care reflects the Russian commitment to prevention. In the belief that preventive health services have their greatest impact during the early stages of a child's development, the Russians maintain a continuing program of medical screening, case-finding, early diagnosis and treatment for their youngsters.

The delegation visited a typical children's polyclinic—#22, located on the first floor of an apartment house in the heart of the city of Moscow. This clinic serves 10,000 children from infancy to 16 years of age. The district is further divided into 12 uchastoks, with a pediatrician assigned to each.

There are more than 70,000 pediatricians in the U.S.S.R., as compared to some 15,000 in the United States. They are trained in specialized schools; and, although the curriculum is in some degree comparable to the six-year course for physicians in general practice, it is designed to provide an intensive education in the medical care of children.

The children's polyclinic is also the prime medical center for all the schools in the district. In the area covered by Polyclinic #22, there are 22 kindergartens, nine regular elementary schools and one boarding school which constantly call upon the staff of the clinic. When a child is ready for kindergarten at the age of three years, it is the polyclinic that gives him a full physical examination. The same process is repeated when he enters elementary school at the age of seven.

The staff at #22 informed us that parents are quite aggressive about getting the best possible care for their children; if they are not satisfied, they complain either to the medical director of the polyclinic or they march off to the local Ministry of Health and present their real or alleged grievances.

With this kind of continuity of care as a base, it is usually the pediatrician who first detects emotional problems in children. In addition to the various mandatory examinations of the child which may give the pediatrician some clues, she knows the family situation intimately. From the time of the child's birth, the pediatrician has spent a great deal of time with the family and can make a judgment based on a whole set of factors which would not become apparent to her in a perfunctory clinic visit. Additional psychiatric referrals come from the nurseries and kindergartens in which Russian children spend a great deal of their time.

The children's neuropsychiatric dispensary is the focal point for the professional practice of child psychiatry. In addition to providing clinical evaluation and consultation for the more difficult psychiatric cases, the dispensary has facilities for both inpatient and outpatient care and serves as a major training resource for child psychiatrists. However, although the child psychiatrists are assigned to this regional neuropsychiatric dispensary, they do a large majority of their treatment work at the district children's polyclinic.

Partially because of this arrangement, the delegation was impressed by what appeared to be a closer collaboration between somatic and psychiatric medicine in the children's services than in the adult service pattern. The fact that the child psychiatrist has an office in, and works from, the polyclinic is further specific evidence of the close alliance in the Soviet Union between psychiatry and pediatrics. This alliance stems from their training, for child psychiatrists are ordinarily graduated from a pediatric medical program before they can seek specialization in child psychiatry. In contrast to the large number of pediatricians in the U.S.S.R., there still is reported to be a shortage of child psychiatrists, since they are usually not accepted for advance training as residents in child psychiatry until they have completed

The #1 Children's Dispensary, Moscow.

a minimum of three years in practice as pediatricians. There is no prescribed duration for advance training, but the delegation was informed that it runs anywhere from one to two years. The total number of child psychiatrists in the U.S.S.R. was estimated as between 1,000 and 1,500.

When children and adolescents are emotionally disturbed or mentally ill, they are treated in one or more of several types of facilities, depending on their age, the diagnosis of illness, and the decision by the child psychiatrist of the treatment which will have the highest capacity to improve the individual child's condition.

Since psychiatric assistance to children and adolescents in Russia is the most recent program of mental health services in the country, it has been developed as a comprehensive and interlocking program, administered by three agencies of the government—the ministries of health, welfare, and education.

The child NP dispensaries, and child psychiatric hospitals serve as the nucleus of the entire program under the Ministry of Health. Institutions under the Ministry of Education include special schools, homes for children and kindergartens for the mentally retarded, for neurotics, and for children with speech disorders. The children's homes for the seriously mentally retarded and for children with physical defects are the concern of the Ministry of Welfare.

The delegation was repeatedly made aware that the Russians are particularly concerned with speech disorders and feel that if they are not corrected early, they can lead to serious maladjustment. Every children's polyclinic has a speech specialist (logoped) on the staff; for the Russians felt that a period of inpatient treatment and corrective instruction at the NP dispensary was often more effective than outpatient care.

Follow-up care is particularly important at the dispensary. Although a child may be admitted because he presents a particularly difficult problem, the dispensary is organized to provide short-term treatment. At Children's Dispensary #1 in Moscow, the median length of stay was three months. When discharged, a child would either continue to be treated at the appropriate polyclinic, with the NP dispensary providing consultation, or, if further treatment was necessary, he would be sent to one of the facilities specializing in longer-term care. As with the adult system, hospitalization of children was not regarded as a measure of desperation, but as an often appropriate and necessary procedure.

The delegation found it somewhat difficult to classify the various residential facilities for children and adolescents in relationship to their specific functions. However, they generally parallel those available for adults except that children's facilities place greater emphasis on education.

In addition to the beds at the NP dispensaries, residential facilities include sanitaria, Homes for Invalids, specialized children's hospitals and Forest Schools. There are also specialized schools for mentally retarded children, those with cerebral palsy and speech disorders, and for children who are severe disciplinary problems.

Reasons for admission to these facilities often depend less on severity of the case than on social factors. It was the delegation's impression, for example, that a child with a learning difficulty, in a particularly stressful situation at home, might well be referred to a sanitarium for a temporary respite from tension as well as for a period of intensive instruction. The sanitaria are relatively small units with facilities for thirty-five to forty children each; there are approximately 500 beds in the children's sanitaria located throughout Moscow.

The delegation did not visit a Forest School, but it was reported that there are three such schools in Moscow, located in "greenbelt" areas, with a total population of some 510 children. These schools are for more disturbed children—particularly those with neurological problems—where, for a year or so, the care emphasizes work-study activities and strict conditioning procedures directed toward changes in attitude.

The children's Homes for Invalids, like their adult counterparts, are for children with chronic and/or severe disabling disorders. There are three such homes in Moscow—one for schizophrenics, one for the severely mentally retarded and one for children with severe organic problems. The delegation did not visit any of these facilities in Moscow, but our impression—based on a visit to a home for retarded children in Leningrad—was that the atmosphere in these specialized facilities is more that of a school than of a hospital.

This follows the Russian pattern in which the school is closely linked to the children's health care system, based on consultation between polyclinic pediatricians and psychiatrists with the teachers.

For the pre-schooler (aged 3 to 7) in need of special attention, there is a system of nurseries and specialized kindergartens, where parents pay the same fee charged by the regular pre-school facilities. In Moscow, it was reported that there are approximately 700 children in the special schools.

Additionally, there were two schools for children with cerebral palsy, two for children with speech disorders and a kindergarten for the mentally retarded. This facility was particularly interesting to us; the children lived at the school five days a week and went home to their families on weekends.

Schoolboys play basketball in Moscow.

Upon "graduation" it seemed possible that some children might be able to enter the regular school system, but it was our impression that most of them would probably continue in a school for older retarded children or be sent to a children's Home for Invalids. However, the delegation saw evidence of the total push approach by the staff to bring these youngsters to an educational level where they could enter public school and be kept within the community.

The very existence of this specialized school was instructive to anyone who has been told that the emphasis in Russian psychiatry is on restoring the citizen to a productive role. Few of the children the delegation saw at this kindergarten would ever become normally productive citizens, yet the Russians were allocated scarce personnel and funds in an effort to bring these children up to a minimal level of performance. They were not being written off as hopeless.

The child psychiatric hospital, in structure and activity, is almost identical to the psychiatric hospitals for adults. However, the children's hospitals include isolation wards for patients with infectious or other physical diseases; and the staff includes one or more pediatricians. Here again, medical and psychiatric treatment are provided in combination with educational conditioning, school work and speech therapy.

The child psychiatric hospital has at least three departments: school-age boys, school-age girls and coeducational preschool children. It admits children 4 to 14 years of age; the hospital for adolescents admits the 15- to 17-year age group; and children under 4 needing inpatient care are placed in the NP departments of general pediatrics clinics.

The delegation found it difficult to make a judgment on the quality of psychiatric services in the children's polyclinics. There is no doubt that it is a great advantage to combine pediatric and psychiatric services under one roof, to have continuing consultation between the two disciplines which have so much to do with the successful maturation of the child. However, at one visit, the delegation became aware both of the shortage of child psychiatrists and the range of professional ability, where one psychiatrist had an impossible, *active* caseload of 190 children, was highly organic in her orientation and expressed her greatest interests in mental retardation, the curative aspects of gymnastics, and the beneficial properties of Vitamin B–12.

On the other side of the ledger, in our visit to the NP dispensary serving ten Moscow polyclinics, the delegation was favorably impressed by the staff that included 11 child psychiatrists, 10 nurses and 10 logopeds, as well as by their detailed follow-up procedures for emotionally disturbed children.

Certainly, the Russian children's polyclinic—strongly reinforced by the children's department of the NP dispensary—is superior to the American child guidance clinic service program. Until extremely recently and quite selectively, the continuity of service for children in the United States has been almost totally absent, with very little in the way of mutual consultation and medical follow-up. The Russian system is impressive because it is based on joint pediatric and psychiatric responsibility for the child and their responsibility continues into the schools, without jurisdictional difficulties.

Youngsters at a children's hospital in Moscow working with beads and embroidery.

Even with this coordination, however, the delegation found that there still seems to be considerable uncertainty as to where treatment of children and adolescents should best take place. We agreed that the services for children, while internally coordinated, seemed less well-defined than those for adults. This should not be taken as a disparagement of the quality of children's services, which the delegation regarded as being, generally, on a high level.

These were our major impressions from observation of children's health services in the U.S.S.R., but one other element of the child care program is worthy of comment. The delegation agreed that in the various facilities we visited, one of the most striking aspects of the children's services—and for adults as well—was the sensitive, warm and often devoted care displayed by the professional staff.

To be sure, most of these facilities were very richly staffed by American standards and there were sufficient personnel available to provide truly individual attention. This quality of care, however, went beyond numbers. Although children in the Soviet Union may be regarded as future resources of the State, the delegation saw too many examples of warm concern being expressed to severely impaired and "unproductive" children to feel that the capacity to contribute to society was an ultimate measure of an individual's worth in the U.S.S.R.

Psychiatric Manpower and Training

MANPOWER

The Soviet Union is engaged in a massive and well-planned effort to train large quantities of physicians and other medical personnel to meet its goal of bringing medical and health care to all its citizens. One of the more conspicuous features of the Russian health care system is the degree to which it succeeds in training professional medical personnel to staff the various facilities. Furthermore, as the delegation was frequently reminded, the entire training program has been developed in 50 years.

When the Soviets assumed power in 1917, there were approximately 30,000 physicians in Russia and much of the medical care was provided by feldshers (medical technicians). There are now over 525,000 physicians in the Soviet Union—more than double the number in the United States—and their 82 medical schools graduate 35,000 doctors annually. This compares with the approximately 8,000 medical students graduated from 88 American medical schools in 1967.

The delegation observed repeated evidence of the plethora of professional staff in the facilities we visited. The average neuropsychiatric dispensary is reported to have 15 to 25 psychiatrists on its staff and there are 19 such dispensaries in Moscow alone. The medical unit at the Likachov Motor Factory had more than 150 staff physicians and 450 other medical personnel, and while it is one of the largest factories in the Soviet Union, the ratios of staff to patients were reported to be similar elsewhere. At the Kaschenko hospital in

Moscow, there were 160 psychiatrists to 2,600 beds—a 1-to-16 ratio—plus 800 nurses and additional ward personnel.

TRAINING

The delegation did not have sufficient time to study the calibre of psychiatric training in depth; on the whole, however, we were favorably impressed by the sensitivity and clinical skill of the psychiatrists we met. On the basis of our observations, we could find no justification for a contention that the Russian psychiatrist is the product of an inferior educational program.

Educationally, the period of initial training for the Soviet psychiatrist is somewhat shorter than for his, or more likely, her, American counterpart. In Russia nearly 80 percent of the psychiatrists and 70 to 75 percent of all physicians are women. The medical school course begins after ten years of schooling—comparable to primary and secondary education in the United States—and is of six years' duration.

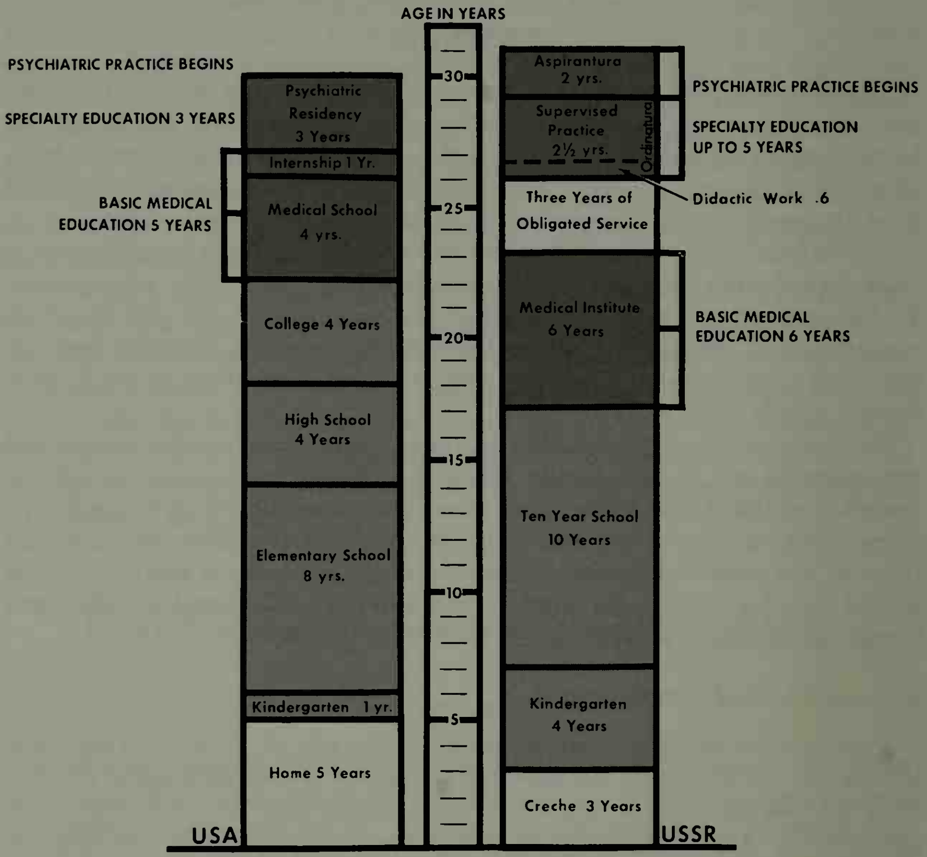
However, continuing education is almost universally sought by medical professionals and is periodically required. The newly graduated physician is always assigned to an experienced group; he is never in solo practice. Every three years, in rural areas, and every five years in the cities, he must take three to five months of postgraduate training. While he is away, his place is held open for him and his salary is paid. For the medical student, a diploma is only the beginning of a lifetime of learning.

General Medical Curriculum

Russian students enter medical school at the age of 17 or 18. Their first three years correspond to the pre-clinical years in American medical schools, with the last three years oriented toward clinical medicine and work with patients. By American standards, the Soviet medical schools are large. A

Dr. Yolles with Dr. Maya Shchirina at the Europa Hotel, Leningrad.

BASIC PATTERN OF PSYCHIATRIC EDUCATION IN USA AND USSR 1968



number of them have 3,000 to 4,000 students. During the pre-clinical years, the formal lecture classes are quite large, but in the last three years, these huge classes are divided into groups of 15 to 20 students.

In terms of psychiatric training, the medical student is first introduced to the human mind with a third-year course in medical psychology. All medical students, in their sixth and final year, are required to take 96 hours of lectures in psychiatry, followed by a two-week clinical clerkship at the bedside in a mental hospital. Students who elect psychiatry as their prospective specialty receive an additional two months of psychiatric training during this final year at a mental hospital, where they receive instruction by the psychiatry faculty, in seminars of 20 to 30 students.

Following graduation, all physicians are required to practice for three years of obligated service, before they can enter specialized training. Because of this requirement, the Russians are able to maintain a reasonable degree of geographic dispersion of medical personnel, for the physician entering practice is required to serve in any part of the U.S.S.R. to which he is assigned.

There is also, however, an adverse result to obligated service. Many a young doctor is first assigned as a uchastok physician, where he serves his three years and then usually enters specialty training. Inasmuch as the U.S.S.R. medical care system is based on the physician in the micro district whose responsibility is the general medical care of a panel of assigned patients, the quality of that physician's service is most important. Admittedly, maintenance of the quality of the uchastok physician and the Soviet ability to hold qualified men in these positions is one of the major problems to be faced, as the population explodes numerically and congregates in vertical apartment cities.

How to keep a man interested in family practice, how to keep some of the best men in general practice to effect real continuity of care remains an unsolved problem in the U.S.S.R. economy, just as it is in the United States. The delegation found not the slightest evidence that the Russians have succeeded in reversing the trend of the majority of physicians to specialization in medicine.

The training of physicians in any of the specialties involves three postgraduate years of instruction, of which six months are spent in didactic work and two and one-half years in practice under supervision. This three-year

Plaque of V. M. Bekhterev above the library door at the Institute in Leningrad that bears his name.

The delegation, with interpreter, in Leningrad.

period—termed the Ordinatura—is roughly equivalent to an American medical residency. Beyond the Ordinatura, the specialist may seek additional training to reach the Aspirantura level of academician or research specialist. This involves two further years of research work and the preparation of a thesis.

Specialized Training in Psychiatry

Specialty training in psychiatry during the two years of residency may be given under the auspices of one of the Postgraduate Institutes for the Advanced Training of Physicians, or at one of the medical faculties for postgraduate training. However, a great many residents receive their psychiatric training under the traditional preceptorship system, working in a mental hospital or a neuropsychiatric dispensary under supervision of senior psychiatric staff.

There is no national certification similar to our American Board of Psychiatry and Neurology. Candidates who have completed the required number of years are examined and certified by the Postgraduate Institute or by the senior staff of the hospital which has conducted the training.

The psychiatrist's training experience does not end with the residency. For example, if he wishes to continue study of Russian techniques in psychotherapy, he may attend one of the few hospitals or institutes in which he can receive advanced instruction in this form of therapy. There is no prescribed duration for such psychotherapeutic training; it may run from three months to a year.

The delegation was told that there is a wide variation in quality of trainees and in training, from institute to institute. Since there is no national medical board examination when an institute examines one of its students, some equalization is introduced into the system by inviting a professor from another institute to participate in the examination of the student's competence in the diagnosis and recognition of mental disorders, specific techniques including individual and group therapy, and the indications for drugs, insulin and EST. We saw no evidence of ward-round teaching or of ward-conference teaching, although the latter may be used in the lecture presentations.

The training of the child psychiatrist is quite different from that in America. As the delegation became aware in observations of the children's polyclinic, the relationship between the pediatrician and the child psychiatrist is one of close coordination. Most residents in child psychiatry are graduates of a pediatric medical school; and they are usually not accepted for advanced training in child psychiatry until they have completed a minimum of three

Dr. G. V. Zenevitch, Dr. Y. S. Averbuch and Dr. Walter Barton at the Bekhterev Psychoneurological Research Institute.

Vinnitsa Mental Hospital, the Ukraine.

years in pediatric practice. There is no prescribed duration for training in child psychiatry, but we were informed that it requires anything from one to two years.

The delegation was also informed that there is a shortage of child psychiatrists in the U.S.S.R. Since a doctor completes his obligated service prior to specialization, the gravitation of specialists toward practice in the cities, combined with this shortage, probably accounts for our delegation's impression that psychiatric staffing in both adult and children's facilities in the rural areas poses more of a problem than the equitable distribution of other medical specialists.

To the best of the delegation's knowledge, there are approximately 9,000 psychiatrists in the U.S.S.R., of whom 1,000 to 1,500 are child psychiatrists. There are also reportedly some 12,000 neurologists. The primary practice for the neurologist is the treatment of classical neurological disorders; but he does assist in the treatment of epilepsy, mental retardation and organic brain damage. The neurologist is not considered to be interchangeable with the psychiatrist, but in areas where psychiatrists are not readily available, the neurologist may also treat mild cases of mental disorder.

Psychiatrists in the Soviet Union are also benefitted by the emphasis on continuing education, for in recent years there has been a particular emphasis on training the general practitioner in psychiatric techniques. We were informed that the three-month courses have proved to be quite popular and at several training centers, applications are reported to exceed the capacity of the center. As additional numbers of GP's receive this training, they should be able to assume more of the responsibility for early diagnosis of mental disorders in the polyclinics, and for collaboration in the follow-up of mental patients.

Training of Paramedical Personnel

The delegation was informed that the education of para-medical personnel is expanding constantly. There are approximately 600 training schools in the U.S.S.R. with a current enrollment of some 300,000 students. These schools are training nurses, feldshers, midwives, pharmacists and laboratory technicians.

The delegation did not have the opportunity to become informed on the particulars of training of medical personnel other than that of physicians. However, we were told that nurses may be trained in various types of hospitals, in any of several medical specialty settings, including psychiatry; but that under the law, nurses can practice anywhere. A nurse completes training in three years; she is encouraged to continue training, if she wishes, and many do so—some, to complete training as doctors of medicine.

The feldsher (medical technician) receives four years of training, including three years basic nursing training and one year of training in order that he may assume responsibility for minor surgery, emergencies, traumatic surgery, and to qualify as a technician specialist in a selected field of medical service. In medical work, the feldsher has more prestige than does the nurse and is trained to accept greater individual responsibility.

The Soviet health care system does not include social work, occupational therapy or recreational therapy within its professional framework. Tasks assigned to this personnel in the United States are performed in Russia by psychiatrists and nurses. In the Soviet view, psychologists are not considered to be health professionals and are not utilized as therapists. The few psychologists are employed in psychological research.

Soviet Customs of Medical Practice

Reflecting the close relationship between government and health care, planning, salaries and fringe benefits can be readily varied throughout the Soviet

Members of the staff at Mental Hospital #14 in Ramenskoy Village.

Union, in order to attract personnel to an understaffed geographical area, or to meet the requirements of a table of organization within a specific facility.

The young physician working a single "tour of duty" or work shift will be paid 180 rubles a month, while his more experienced colleagues receive 250 rubles. The maximum for a practicing physician is understood to be approximately 450 rubles per month. Nursing salaries range from 100 to 200 rubles a month for a single tour of duty, while the feldsher earns approximately 100 rubles a month. (A ruble equals $1.11 on the official exchange).

Hospital orderlies are currently paid at the rate of 75 rubles a month, which is low by Russian standards, since the minimum wage is 60 rubles. As a result, the Russians reported difficulty in the recruitment and retention of orderlies and aides in the hospital system since, in addition to the low pay, there are few of the prerequisites that are accorded to other medical personnel.

Even for physicians, the salaries are not particularly high; a taxi or bus driver earns 250 rubles, while a skilled factory worker may receive as much as 500 rubles a month. However, people are attracted to the medical field by the fringe benefits.

In addition to personal satisfactions of the professions, the standard working day is not long. It varies from 5½ to 6½ hours a day for a five day week and it is widely customary for an individual to work a shift and a fraction, or a double shift day, either to earn more income, or because the facility requires additional staffing hours to meet its service requirements. If a physician wishes to do so, he has the opportunity of taking a second full time job; medicine is the only occupation accorded this privilege.

All physicians and other medical workers receive 48 days of vacation annually. The professions are particularly attractive to women who wish to have a career and also attend to their families; and for women, retirement—and thereby pension age—is available to them at age 50 as contrasted to age 55 in other occupations. These benefits, added to the esteem in which physicians are held in the Soviet Union, account for the lack of difficulty in recruitment, despite the average financial remuneration.

The delegation inquired as to whether any physicians were engaged in private practice and was told that a few well known physicians did maintain part time private practices. These are usually physicians who have earned prestige reputations as university professors, academicians and research specialists; their average fee for a private consultation is from one to three rubles; and three rubles is apparently the fee of a top professor.

After touring many hospitals and clinics and talking to scores of psychiatrists, the delegation was quite favorably impressed with the clinical acumen which they bring to their patients. These psychiatrists have a very definite clinical flair; and the warm rapport between the psychiatrist and the patient, which we witnessed everywhere, is evidence that they have been taught to work empirically with the patient, not according to any preconceived and rigid set of diagnostic classifications. Medical manpower in the Soviet Union has been developed in a realistic attempt to create sufficient numbers of appropriate personnel to meet the requirements of the health service system and those of an expanding population.

PART II

The Interface Between Russian Psychiatry and the Law

INTRODUCTION

An area of interest to the delegation—but one not usually amenable to investigation by mental health professionals—was the interface between Russian psychiatry and the law. Although the complete delegation was unable to pursue this matter in depth, one member, by virtue of his legal interests and expertise, devoted considerable time and energy to exploring the legal aspects of the Soviet approach to mental illness.

This portion of the delegation report presents the results of that investigation. The first section is a discussion of the Russians' concept of criminal responsibility (termed "imputability"). It includes a review of the past and current standards for imputing blame, a delineation of the procedures by which this is accomplished and an examination of the roles played by courts—and psychiatrists—in the process.

The second section reviews civil (or non-criminal) commitment procedures. Civil commitment is harder to describe accurately than its criminal counterpart, because the Russian national health system, with its emphasis on early intervention and outpatient treatment, makes it difficult to determine the point at which mere "treatment" has become "commitment" for treatment. Nonetheless, an attempt is made to clarify the Soviet practice by examining those points in the treatment process at which a mentally ill citizen's relations with his society are legally altered.

The third section is more interpretive than descriptive. It is, in effect, a review of the preceding material with a special emphasis on raising issues of relevance to American mental health and legal professionals.

The report concludes with a number of appendices of special interest. Included are translations of certain Russian documents which shed light on the relationship between psychiatry and the law and which are not readily available elsewhere.

The Determination of Criminal Responsibility

Historical Background

After the Russian revolution, the question of the criminal responsibility of the mentally ill was at first taken entirely out of the hands of the courts and made solely a medical judgment. Article 14 of the "Leading Principals of Criminal Law" of 1919 stated: "A person shall not be subject to trial and to punishment for a deed which was committed in a condition of mental illness. . . . To such person shall be applied only medical measures and measures of precaution." [1] This provision was broad enough to require that all persons accused of criminal acts who pleaded mental illness be placed immediately in a hospital. But this startling result is explained by the early Soviet belief that all crimes were medical problems caused by the evils of pre-revolutionary Russian society.

Apparently, however, revolutionary society did not eradicate crime, and this strictly medical view was soon abandoned. Subsequent criminal codes provided that those persons who committed "socially dangerous acts" could be punished if they "acted intentionally or negligently and foresaw, or should have foreseen the socially dangerous consequences of their acts." This traditional language appeared to restore to the courts the issue of responsibility in criminal cases involving the mentally ill. But the criminal code provided for the summoning of a psychiatric expert whenever the mental status of an accused was in doubt. Well into the 1930's this expert in practice decided whether the accused should be excused on account of insanity. And despite court involvement in the process, the psychiatrists apparently continued to make their decisions largely in terms of what they personally regarded as best for the particular offender in question and for society in general.[2]

Reaction to this tendency developed in force in the 1930's, reflecting a renewed emphasis on individual free will and moral responsibility in the official ideology. There was increasing concern about the danger that excused offenders would repeat their crimes, and psychiatrists were instructed to pay more attention to the needs of the legal order. Most important, the final decision on an insanity defense was expressly assigned to the courts. The psychiatrists were only to prepare reports for use by the courts, and their reports were to present both medical *and* legal considerations in language comprehensible to judges and lawyers.

The effect of this change is reflected in the records of the Serbskii Institute of Forensic Psychiatry—the major national institution for the diagnosis and study of the criminally insane. Professor Harold Berman notes that whereas 46.5% of all psychopaths examined at the Serbskii Institute in 1922 were declared "nonimputable," and 29.3% "partially imputable," by 1945 the percentage of psychopaths in the "nonimputable" category had dropped to 12% and the category "partly imputable" had been abolished. Thus, the more socially determined or so-called "reactive conditions" were modified to allow more room for imputability. The label "schizophrenia" was broken down into more precise differentiations for the same reason.[3]

The Present Standard

In the Soviet Union today there is no uniform national standard governing the determination of criminal responsibility, since there is no national criminal code. The closest equivalent to national law is the Federal Fundamental Principles. These Principles, promulgated by the various National Ministries, serve as guidelines to the constituent republics for legislation in a number of areas. The most recent Fundamentals of Criminal Legislation and Criminal Court Procedure were enacted by the Supreme Soviet in December 1958. Article 3 ascribes criminal responsibility to anyone who has "either deliberately or by negligence, committed any of the socially dangerous acts defined by the criminal laws . . ."[4]

There are, however, numerous exceptions to Article 3, many of which broadly comport with American law. Article 10, for example, which deals with juvenile offenders, (a) holds no juvenile under 14 years of age responsible for his criminal acts, (b) holds no juvenile between the ages of fourteen and sixteen responsible for his criminal acts, provided that such act was not one of a number of crimes ranging from murder to serious destruction of private property, and (c) holds no juvenile under eighteen years of age responsible so long as his criminal act did not constitute a serious social danger.[5]

Other Articles provide for a plea of self defense (Article 13) or a plea of "dire necessity" (Article 14). These articles excuse what otherwise might be criminal acts in the circumstances when the accused has acted justifiably either to protect his own life or to "avert a danger threatening the interests of the Soviet State . . ."[6] Not all of the articles, however, excuse responsibility. Article 12, for example, reflecting Soviet concern with the problem of alcoholism, establishes a clearly punitive approach by providing that "a person committing a crime while in a state of drunkenness is not relieved of criminal responsibility."[7]

The above-noted exclusions to Article 3, however, have little to do with the question of criminal responsibility involving mentally ill offenders. It is in Article 11 that this aspect of criminal responsibility is set forth and the basis for an insanity defense developed. Adopted virtually word for word by the constituent republics, Article 11 states:

> *a person who, at the time of the commission of a socially dangerous act is non compos mentis, i.e. unable to account for his actions or to govern them as a consequence of chronic mental disease, temporary mental affliction, weak-mindedness or some other morbid state, is not held criminally responsible. Obligatory medical treament as defined by the legislation of the Union Republics may be applied to such a person by order of the Court. A person who, at the time of the commission of a crime is compos mentis, but who, before sentence is passed by the court, is afflicted by a mental affliction that deprives him of the possibility of accounting for or governing his actions, is also not liable for punishment. By the order of the court compulsory medical treatment may be applied to such a person and on recovery from his illness he may be liable to punishment.*

In form, with its emphasis on the accused's knowledge and/or control of his actions, the Soviet standard for criminal responsibility[8] does not differ from certain Anglo-American tests of criminal responsibility. Yet unlike the McNaughten or Durham rules the Russian standard has evoked little commentary and generated little law.[9] It appears, at least to the delegation, that the Russians are less concerned with many of the issues raised by the standard than in defining the procedures which govern the mental examination of the accused.

In any event, the Russians have placed great responsibility for determining imputibility in the hands of the examining psychiatrist. While judges are still ostensibly free to disregard psychiatric reports, it was the impression of the delegation that they do so only under the most exceptional circumstances. In practice, Russian court psychiatrists seem to make decisions that are virtually unreviewable.

The Russian psychiatrists find this situation altogether unexceptionable. Many of them argued that since they are employed by the state, rather than by the patient or anyone else with a vested interest in the case, they are able to be impartial and objective. The delegation's rejoinder that psychiatrists in most American criminal cases were also paid by the state, but still were not regarded as infallible, did not appear to shake their conviction. They pointed out that, strictly speaking, they were not really regarded as infallible; if they made an error, for example, they could be subject to legal penalties. They could not, however, recall a case in which such penalties had been imposed.

To some extent, the Soviet deference to the medical expert reflects the high regard most courts seem to hold for psychiatric expertise. But in the Soviet Union, this tendency is doubtless enhanced by the requirement that all law students—as a part of their training—must attend an institute of forensic psychiatry for courses on mental illness and the law taught by forensic psychiatrists.

Since the psychiatrists play such a dominant role in determining criminal responsibility, the Soviet attitude toward that problem can be understood only by investigating the process by which psychiatric decisions are reached. Accordingly, the delegation attempted to learn something about the medico-legal psychiatric examination given the accused who may be mentally ill.

Examination by the Medico-Legal Psychiatric Commission

Medico-legal psychiatric examinations are conducted by the Ministry of Health and are governed by a series of interdepartmental instructions which the Health Ministry has coordinated with the Ministries of Justice, Internal Affairs and the Procurator's Office.[10]

Such examination may be requested at any stage of a criminal proceeding prior to sentencing by the accused or his relatives, defense counsel, or physicians, if it appears that the accused, any of the witnesses, or even the victim is suffering from mental illness. The examination may be conducted in a variety of settings (court, hospital, etc.) and the instructions vary according to the conditions under which the examination is held. For example, though as a general rule three psychiatrists must participate, the examination may be conducted by one or two if it is scheduled in a remote area or at a considerable distance from a regional or urban health center.

In a psychiatric facility, however, the hospital's chief physician heads the three-man examining team. His associates are the chief of the medico-legal psychiatric section or another physician similarly trained, and a reporting psychiatrist who is to keep the accused under constant observation. No lawyers are included. But the doctors are encouraged to examine the evidence in the criminal case as well as all available information about the accused's past life and former illnesses. Except in unusual cases, this extensive examination is not to exceed 30 days.

Conclusions are presented in a four-part report. The first section presents a detailed history of the accused, treating such topics as family background, work experience, education, etc. This material is based primarily on information supplied by other agencies rather than on direct investigation by the examiners.

The second section outlines the results of the physical examination. It includes a blood analysis, an EEG, etc., as well as a complete medical history of the subject obtained from any medical facilities at which he may have been a patient. The medical history readily discloses whether other physical and/or mental investigations have ever been made of the accused and if there has been a discernible change in his health.

The third section of the report is devoted to the psychological examination. It presents a detailed description of the accused as developed by psychological testing, interviews, and laboratory reports. It represents one of the few instances where the delegation saw evidence of psychologists functioning in a diagnostic, non-research capacity. It is of interest to note, however, that projective tests were not part of the Russian psychologists' armamentarium, although the Wechsler-Bellevue was employed.

The fourth and final section of the report contains an evaluation of the accused's mental condition at the moment of the commission of the crime and a judgment as to his present competence to stand trial. If requested, it must also indicate whether the accused will be able to serve his sentence in a prison or whether it will be necessary for him to be maintained in a mental institution.

At times the commission may be unable to reach a satisfactory conclusion because the materials submitted to it are inadequate. If so, it must indicate to the court precisely what additional materials are necessary. If such materials are not forthcoming the commission must then explain to the court why it is unable to reach a decision without them.

The court is not obliged to accept the report. If it finds the conclusions unclear or incomplete, or if the experts appear to differ, it may order another examination. The Health Ministry must then form a new panel or, in exceptional cases, may refer the accused to the Serbskii Central Scientific Institute for examination.

The Serbskii Institute

The most prestigious examining institution is the Serbskii Institute. Named after V. P. Serbskii, an important forensic psychiatrist of the 19th century, it was organized in Moscow in 1921 as a center for expert psychiatric examinations and research on forensic psychiatry. In 1932, it was reorganized as a scientific-methodological center serving the whole U.S.S.R.[11]

As with many other buildings visited by the delegation, the looks of the Serbskii Institute belie its importance. It is located in an old section of the city, up a small street. From the outside it is not particularly impressive; it is an old building with an entrance barred by forbidding iron gates. These gates, which slide electrically along tracks to admit visitors, are part of a very tight security system, which includes the use of soldiers as guards. Such elaborate precautions, it was explained, were necessary because the Serbskii examines some of the most difficult cases in the Soviet Union.

On his first visit to Serbskii, the delegation representative was denied permission to observe an expert examination in process. The reason may have been an overly literal interpretation of a Ministry of Health Instruction which threatens psychiatrists with criminal action if they divulge the contents of an examination report in anything other than a judicial context.[12] This provision, however, did not bar visitors from observing an examination if authorized to so do by the Ministry of Health; and on a second visit, when an authorization had been obtained, the opportunity to observe an examination was made available.

The case observed by the delegation member dealt with a woman who had been apprehended for stealing, but who was currently showing symptoms of mental disturbance. Her past history indicated that she had been happily married until her husband was killed during the Second World War. Although deeply depressed by this tragedy, she recovered and ultimately remarried. The second marriage, however, was reportedly unhappy and the accused had entered into an adulterous relationship. She was apparently quite troubled about this, as well as by the fact that her son by her first husband had become a delinquent.

After her first husband's death the woman had gone to work, and despite her personal unhappiness had risen to the position of assistant manager of a shop. All seemed to be going relatively well until a shortage in the inventory was noticed and a criminal investigation was held. Although the woman was not a suspect, she attempted suicide, thereby drawing the attention of the authorities to her. It was discovered that she was indeed involved, and that together with the shop director, she was furtively turning shop merchandise over to a third party for resale.

When these facts had been read to the commission, the woman was brought in. She was obviously very depressed. She declared she did not want to live and did not care to speak with the commission members. Do what you want with me," she said. "I am guilty. Don't torture me."

The commission members displayed great kindness and concern. At one point, they even comforted her, placing their arms around her shoulders. It seemed to the delegation member that the commission would find her nonimputable. However, once the woman left the room, the commission took the opposite position. Her current illness, they believed, was merely a reaction to getting caught. They did not believe that she had been mentally ill at the time of the offense; therefore she could not be excused.

Expert Opinions

In addition to providing an opportunity to observe an examination, the Serbskii Institute also gave the delegation representative two expert commission reports. Since this material is not readily available elsewhere, translations are reproduced in the following pages. These reports provide an accurate picture of the commission examination process, for they indicate the material available to the commission and the manner with which it is dealt.

Compared to the typical hospital report submitted to courts in the United States, they are far more detailed and provide more useful information about an accused's background. They insure, among other things, that it will not be discovered for the first time on an appeal that the accused had only recently been treated for mental illness in another jurisdiction.[13]

File No. ----   IN-PATIENT
concerning a forensic psychiatric expert opinion of the examinee (the accused), Sh.

We, the undersigned, examined Sh., 33, accused of murdering his mother-in-law, his wife and his daughter as well as of maliciously burning his mother-in-law's house; he was examined on September 17, 1966, in the Professor Serbskii Central Scientific Research Institute of Forensic Psychiatry. An examination by a forensic expert was made in compliance with a decision of the Senior Investigator of the District Attorney's Office (*Prokuratura*) of Ivanovskaia Province due to some doubts as to the mental condition of the examinee. The case indicates that Sh. had already been examined as an out-patient by forensic psychiatric experts during his stay in solitary confinement pending the investigation. This commission however did not reach an opinion on the examinee's inputability and recommended that he be sent for an inpatient examination to the Professor Serbskii Institute where the examinee was admitted on August 15, 1966. The following facts are known from statements of the examinee himself, a record of the criminal case, and medical files: the examinee is not afflicted with hereditary mental disorders. His development proceeded normally. During his pre-school years he suffered an inflammation of the inner ear which caused him to be hard of hearing. At 8 he started attending school, with fair results; he repeated the 5th grade. After finishing the 5th grade he worked as a tractor driver and afterwards as an instructor-dog breeder; he did his work satisfactorily, being accurate and industrious. He married and had a daughter. The marital relations, in the beginning, were fine. While visiting relatives he did not write to his wife and after his return home declared that his relatives insisted on his divorcing his wife, asked him to come back home, and promised to contribute to paying alimony and to buying a motorcycle. From this time on family relations became scandalous. He was jealous of his wife, "did not acknowledge the child," "never let his wife out of his sight," locked the door and threatened, with a knife in his hand, to kill his wife and child. His wife left him several times and stayed with her mother, but the examinee went to her, "forcing his way in." His wife was afraid of him and said that "there is going to be a tragedy." Before the law violation in question the examinee was on leave and was about to visit his relatives. His wife, at first, wanted to accompany him; however, afterwards she refused to do so due to her fear of being killed by him. Once she went to a neighbor and with tears in her eyes asked her to accompany her to (word illegible), being afraid of meeting her husband. After she went to her mother's home she said that she had left her husband and would never go back to him. The witnesses, who knew the examinee, describe him as a person of a reserved and taciturn disposition. Before the murder he asked M. for a rifle with two cartridges. At home he put the unloaded gun under the bed and left the cartridges in the kitchen. Then he had one glass of wine and two of beer. That night the house of the examinee's mother-in-law caught fire. In the building were discovered the corpse of the examinee's wife with many injuries on the face, a cut throat and two bullet wounds in her chest, and the corpse of the six months old daughter of the examinee who died in the fire through suffocation. For a long time he would not open the door to outsiders. The examinee's clothing and gun were stained with blood. In the course of the investigation, as the record of the criminal case shows, the examinee answered questions to the point although giving conflicting depositions. Thus he said that he knew nothing about the death of his wife, mother-in-law, and daughter and did not leave his home that night. Later he said that the death of his wife and mother-in-law was caused by his carelessness because his wife and mother-in-law snatched the gun from his hands. A series of the examinee's depositions have been refuted by the testimony of witnesses and the results of the investigation. In the Institute's examination the following was found:

The examinee, of average height, has a normal physical constitution. His heart beats are clear. Blood pressure: 120/80. In the lungs—vesicular breathing. Diagnosis of the therapeutist: no particular changes as far as internal organs are concerned. Diagnosis of the opthalmologist: fundus oculi—normal. On the X-rays: no changes due to bone trauma or otherwise. NEUROPATHOLOGICAL CONDITION: no pupillary or oculomotor disorders. Facial musculature—symmetrical. The tongue, when extended, is centered. Knee and Achilles tendon reflexes—uniform, no pathological reflexes. Wasserman blood reaction (testing syphilis)—negative. PHYSICAL CONDITION: The examinee is calm, sluggish, taciturn. He does not associate, his expression is morose, head—sunken. During a conversation with the physician he answers sparingly but to the point, and does not show a desire to be in touch with anybody. Information given about himself is consistent and coherent. He speaks softly, slowly, his enunciation is correct and grammatical. The examinee complains of vertigo and sleeping badly. He considers himself all right mentally, is displeased to be committed for an examination. The majority of questions concerning the violation of the law he answers with "I do not know, I do not remember." He is sorry about the death of his wife, daughter and mother-in-law. He insists that he loved her and now cannot live without her. He said that their home was haunted by a witch who influenced their life in a bad way. He asks to be put before the court as soon as possible. During the first month of his stay in the Institute he was gloomy, sad, morose, depressed. Later on he became more composed, participated in the working process. The examinee's intellect corresponds to his education, no symptoms of a disordered memory. He critically evaluates the situation in which he is involved, defending his own interests. He does not reveal any psychotic symptoms (delirium, hallucinations, etc.).

On the basis of the above the commission reached the conclusion that Sh. does not suffer from a mental illness. This is indicated by the absence of psychotic symptoms and intellectual disorders. Critical awareness of his present situation. Statements concerning the witch characterize rather a superstition and do not indicate any morbid psychotic condition. As far as Sh.'s psychotic condition at the moment of committing the violation of law is concerned, it is apparent from the files of the criminal case and the data of the psychiatric examination that the examinee did not display in this period any temporary morbid disorder of mental activity; he (rather) was in a state of alcoholic intoxication. This is evidenced by the lack of psychotic symptoms as well as the normal orientation in relation to his surroundings. Therefore Sh. should be considered criminally responsible for the act with which he is charged.

(Signed) Chairman of the Commission: psychiatrist-exper.
Member of the Commission: psychiatrist-exper.
Reporter: psychiatrist-exper.

TRANSLATION FROM RUSSIAN

File No. ——

IN-PATIENT

concerning a forensic psychiatric expert opinion of the examinee, (the accused) P.

We, the undersigned, examined P., 30, accused of attempting to kill his wife, on August 27, 1966; (he was examined) in the Professor Serbskii Central Scientific Research Institute of Forensic Psychiatry. According to the record he was examined as an out-patient by a forensic psychiatric expert; however, due to a vague clinical picture the question of (his) mental disorder and imputability was not decided and (therefore) an in-patient expert examination at the Serbskii Institute of Forensic Psychiatry was recommended. An expert examination was instituted on a decision of the Public Prosecutor, Balashikha, on the grounds that P. had been frequently confined in mental hospitals in the past. From the record of the case, medical documentation, and his own depositions as well as those of his wife, the following facts are known. There is no information on heredity. In his childhood P. grew normally. At the age of 8 he started school and went through the fourth grade. At an early age he started working on a kolkhoz (collective farm). He did not suffer any head trauma. He married at 20 and has two children from his marriage. As to his disposition he was mild and obliging. His industrial work record was good. At 29 it was discovered for the first time that he had tuberculosis and P. was treated as an in-patient. At 25 he became suspicious, particularly of his wife. He believed that his neighbors were conspiring to murder him. He heard calls. Shortly thereafter he had the flu with a high temperature. In these days his anxiety and fears increased; he started to hear neighbors' voices through the walls. These voices had a threatening and imperative character. He behaved abnormally, became aggressive, and was committed for the first time to the Iakovenko mental hospital, with the diagnosis "Alcoholic psychosis on a somatogenic basis. Cavernous form of Tb." He spent two months in this hospital. His mental attitude at that time displayed resentment, inaccessibility, and he had hallucinations and a persecution mania. He was discharged during a stage of remission; however, he behaved abnormally immediately upon being released. He was not able to work. He left his family. When he went home several days later he was suspicious, refused to change his dirty linen, and stopped eating. He accused his wife of being unfaithful to him. He heard voices. He held his ear to the wall and asked other persons to do the same to listen with him. He became aggressive. At night he attempted to strangle his wife and after one month he was again committed to the same hospital. This time the diagnosis was "Schizophrenia, paranoic form." He was treated with massive doses of aminazine and stelazine, however, without any particular result. He was discharged after 3½ months in a stage of some remission. One year later he was again committed to the Iakovenko Hospital with the previous symptoms and diagnosis, "Schizophrenia, paranoid form." The commission (i.e., the undersigned members) were given the original files of the history of his illness. At home he continuously behaved abnormally. He persecuted his wife, attempting to strangle her several times at night. He spent most of his time in his wife's coat closet staring at the windows of the kindergarten where his wife worked. He bought knives, threatened assassination. He contended that his wife was unfaithful to him. Once in a state of intoxication he injured his wife in the chest and twice hit her on the back but was stopped by neighbors. During an examination while an outpatient he displayed signs of jealousy. He attracted attention by his apathy and depression. During examination in the Institute the following somatic condition was found:

Skin color—gray, skin covered with perspiration, subfebrile condition. Thorax—hollow. Cough with sputum. Ausculation reveals many moist rales in the lungs. Short breath. Heart sounds muffled. No irregularities of other organs. Chest X-ray—plenty of shadows on the left, calcified lymph nodes in the rhizosphere. In the sputum—Koch bacilli (Tb) have been found. As far as neurologic condition was concerned no deviations from the norm were revealed. PHYSICAL CONDITION. Examinee's orientation is formal (sic, apparently should be normal). Facial expression—poor, immobile, Voice without modulation. Answers all questions monotonously. Sparingly and unwillingly talks about his life. Stubbornly conceals his past psychotic experiences, trying to explain everything by conditions of life. Unwillingly told that voices have bothered him for a long time. After treatment at the hospital the fears diminished. However, at home he again started to suspect his wife was poisoning him, heard voices, felt some influence exerted "on his head": strange thoughts were put there. Seems that there is some center from which he is being watched, all his movements controlled. He surmised that his wife was conspiring with neighbors to kill him. Noticed that he was shadowed everywhere. In this period of time, according to his own story, he overindulged in alcohol since intoxication brought "spiritual relief." In (his) room in the Institute he does not associate with anybody, is inert, apathetic, without initiative. He shows no interest in his fate. He never engages in anything useful. He complains of being bothered by voices. He is convinced that "his wife is after him." He remains inaccessible, with great difficulty tells about his experiences. He is not aware of the reason for his being committed to the Institute, assuming that his wife lets him stay in the hospital to get rid of him. He does not show any signs of regret over what he has done or interest in his wife's and children's future. His thinking is diffused and amorphous. His judgments are sometimes paralogistic. His emotions are debilitated, inadequate. Uncritical of his condition. Taking into consideration the above the (undersigned) Commission has reached the conclusion that P. is suffering from a chronic mental illness in the form of schizophrenia complicated by alcoholism on a somatically changed basis (active Tb.). This diagnosis is based on anamestic data taken from (his) medical history as well as from the results of clinical tests made at the Institute which revealed persecution delusions and the delusion that people try to influence him; he has hallucinations (and a) syndrome of diffuse thoughts (otkrytost' myslei) as well as emotional depression and volitional disorders which are characteristic of a schizophrenia process. Therefore P., as an insane person, should be considered not criminally responsible for the act of which he is accused and which was committed in a morbid state. P.'s mental condition requires compulsory treatment in a mental hospital of a general kind.

Signed: Chairman of the Commission: psychiatrist-expert.
Member of the Commission: psychiatrist-expert.
Reporter:

Trial and Treatment

If, on the basis of the commission reports, the court finds an accused non-imputable, he is subjected to what the codes of criminal procedure call "compulsory treatment."[14] If he is considered dangerous, he may be sent to a hospital operated by the correctional system, designed primarily for the post-conviction treatment of persons found responsible for their crimes but mentally ill.[15] The delegation representative did not have an opportunity to visit any of these facilities, but the delegation representative was told that relatively few non-imputable prisoners were placed in them.

Typically compulsory treatment for the non-imputable is provided instead in hospitals run by the Ministry of Health. Compulsory treatment is not regarded as punishment, and the kind or conditions of treatment cannot be dictated by the court. Thus, when the doctors decide that a patient is cured or sufficiently improved as to be no longer likely to commit crimes, he may be discharged from the hospital apparently without any judicial intervention.[16] In practical effect, compulsory treatment does not appear to differ significantly from civil commitment. Under both procedures, patients are ordinarily sent to mental hospitals near their homes and treated just like any other patient.

Patients under compulsory treatment are entitled to a re-examination every six months[17] to determine whether they should be transferred to another facility or even released. This administrative procedure, conducted by the hospital without any judicial control, appears to be the only form of review available to those who have been committed through the criminal process.

As indicated, criminals found responsible but mentally ill may also be committed to compulsory treatment, though they are not ordinarily sent to Health

Cathedrals in the Kremlin.

Ministry hospitals. Alternatively, the court may simply impose a less severe sentence on such offenders.

In cases where the commission report finds no mental illness, the accused will, in all likelihood, be sentenced to a correctional institution. Should he subsequently become mentally ill while serving his sentence, it appears that the court can order a commission examination. However, while there is some room for doubt, it was the impression of the delegation representative that even if the commission should find the prisoner mentally ill, he would probably not be transferred from a correctional system hospital to a Ministry of Health facility.

The Russian View of Criminal Responsibility

Most Russian psychiatrists interviewed by the delegation believe there is a distinct, medically ascertainable line between the responsible and the non-responsible defendant. In their view, a person is irresponsible only if his behaviour is determined by a quantifiable *organic* abnormality. Psychological maladjustments do not amount to irresponsibility unless they have organic roots. Similarly, environmental influences such as poverty are by and large irrelevant to medical diagnoses. They may be considered only if they result in some clearly discernible physiological change. Indeed, D. R. Lunts, an important official at Serbskii, argues that to consider such factors would be to invade the province of the courts, who are to weigh them in imposing punishment.[18]

Again, the psychiatrists insisted that the commission's recommendations, based on their strictly "medical" analysis, were not always followed by the courts. Unlike the psychiatrists, the Russian jurists were able to point to one recent case—reproduced in the appendix—where the decision of a medico-legal commission was actually overruled. The case involved a murder which developed out of a fight between two drinking companions. The question considered by the Supreme Court was whether there had been an "intentional homicide committed in a state of strong mental agitation," or only an "intentional homicide." Although the trial court, following the commission's recommendation, had said it was the former, the Supreme Court reversed. It concluded that the murderer acted while under the influence of alcohol, thereby negating the claim to any "sudden mental agitation." This is indeed a reversal of a commission's report, but it does not appear to be a typical case. It deals with the very sensitive issue of alcoholism, and the Russians impose absolute responsibility even on alcoholics for crimes committed under the influence of intoxication.

It appears that there are at least several psychiatrists in the Soviet Union who are troubled by the assumption that there is a clear, medically ascertainable line between the responsible and the nonresponsible defendant. S. M. Semenov, for example, writing in the Soviet Journal of Neuropathology and Psychiatry, points out that different psychiatrists often have different views as to whether a given mental illness constitutes an excuse for criminal behavior.[19] Semenov argues that there is a great deal of subjectivity in the psychiatric expert's recommendations, and that such subjectivity is increased by the fact that psychiatrists are forced to make either-or decisions. To remedy the situation, Semenov suggests the adoption of an additional verdict of "diminished responsibility."

To the extent that this article acknowledges the difficulty, indeed impossibility, of always arriving at clear-cut medical judgments on responsibility, it is highly significant. It is also of interest to note that this article was given to the delegation by Dr. Lunts, a leading critic of Semenov's position.[20]

Legal Aspects of the Treatment of Mental Patients

The emphasis in the Russian psychiatric system on early intervention and outpatient treatment has been outlined in earlier parts of this report. This emphasis has important consequences for the institution of civil commitment. Unlike its American counterpart, civil commitment in the Soviet Union involves more than the procedures governing hospital admission, treatment and discharge. Given the many opportunities for outpatient treatment without confinement the point at which a citizen becomes a "mental patient" for purposes of deprivation of his liberty or modification of his rights is much less clearly defined than it is in the United States.

Voluntary Hospitalization

In the Soviet Union, a commitment is deemed voluntary whenever the patient's family, his trade union, business organization or polyclinic physician requests it. The Russian attitude seems to be that if the patient were able to make a rational decision, under the circumstances, he, too, would seek hospitalization. As a result, only three to four percent of all commitments are termed "involuntary."[21] In many respects this attitude is not too different from that of some American psychiatrists who, ignoring the statutory requirement that a person must be dangerous as well as mentally ill, seek to commit any person they regard as needing immediate treatment. They too are acting for the patient's own benefit. And these psychiatrists, both Russian and American, may be right. Perhaps people who need treatment should be involuntarily hospitalized for their own benefit, even if they are not dangerous. But the delegation was made acutely aware of this issue by the Russian practice, and clearly this is a decision which must be made by society as a whole—not by the psychiatric profession alone or by individual psychiatrists.

The procedures for voluntary hospitalization in the Soviet Union, as in most American jurisdictions, are quite informal. A person may be hospitalized if a psychiatrist certifies that he is in need of treatment.[22] However, since a number of other treatment options are available to the psychiatrist including outpatient care or day hospitalization, in practice commitment to a hospital seems limited to those cases where restraint and/or observation seem necessary.

Emergency or Involuntary Hospitalization

The procedures for involuntary commitment are more formal than those for voluntary commitment.[23] In essence, the Russian standard is similar to the American: the patient, as a result of his mental disturbance, must be dangerous to himself or others. Alcoholism and drug addiction are not considered mental illnesses as such and therefore cannot be dealt with by civil commitment procedures.

The decision to seek involuntary commitment may be reached through the same routes which lead to voluntary hospitalization. However, for involuntary commitment the recommending physician must additionally provide a detailed report of the factors which, in his judgment, indicate the need for emergency procedures. Specific provision is made for calling the police "when objections are raised by the patient's relatives or guardians and when they offer resistance."

Once a patient has been committed in accordance with the regulations, a special commission of three psychiatric experts must determine within 24 hours whether continued involuntary commitment is necessary. This commission, like the medico-legal psychiatric commission, is governed by instructions issued by the Ministry of Health and which have been coordinated with the Procurator's Office and the Ministry of Internal Affairs. These instructions give no indication as to the nature of the hearing the Commission must hold, or whether the patient is allowed counsel. They seem more concerned with delineating as clearly as possible the various types of mental illness which justify commitment. They also list a number of situations which indicate "dangerousness," but the list does not limit the psychiatrist's discretion. The instructions allow commitment even when the citizen is not visibly dangerous, stating that the specified mental illnesses "which contain doubtless social dangers, may be accompanied by extremely correct behavior and dissimulation."

Soviet law requires that the commited patient be placed in a ward appropriate to his psychiatric condition for the purpose of "active therapy." [24] At least in theory, then, it appears that the Russians recognize a committed patient's right to treatment. As previously indicated, it appears so in practice as well, and the patient is entitled to re-examination by a three-man commission at least once a month for the purpose of determining whether hospitalization is still required.[25]

Patients are released from involuntary commitment following a determination by the psychiatric commission that the patient has improved or is no longer dangerous. The patient is then placed in the custody of his family or guardian, who is expected to maintain contact with the local neuropsychiatric dispensary. If the patient has no family, he will remain hospitalized until such time as a guardian can be appointed.

Outpatient Treatment

As previously indicated, the development of an outpatient oriented treatment framework in the Soviet Union was as much a matter of necessity as of conviction.[26] Although it is now believed that returning the patient to the community and to a job is more therapeutic than maintaining him in the hospital, the original impetus for this development was the lack of inpatient facilities.[27]

In any case, both voluntary and involuntary patients in the Soviet Union are eligible for conditional release as outpatients. The discharged outpatient is placed under the guardianship of a family (preferably his own) or of a collective farm.[28] He is given a job commensurate with his medical condition and current work skills. While the guardian provides the environmental conditions necessary for improving the patient's health, the hospital continues to supervise the patient's medical progress and to assist the guardian in the patient's care. The effectiveness of the guardianship arrangement is assured by a high degree of government control. Medical authorities, for example, can require a factory or collective farm to provide work for an outpatient, despite the fact that his job performance is less than adequate. In addition, many psychiatric facilities are able to provide apartments for patients and a guardianship family may be offered a larger apartment if this would contribute to a patient's recovery.

Commitment and Legal Rights

Depending on the patient's condition, entry into the psychiatric system may or may not affect his legal status. If he is not seriously disturbed there may be at most a slight alteration in his pension rights. On the other hand, if he is seriously disturbed, there may be formal proceedings which lead to appointment of a guardian, certification of insanity or certification of the patient's inability to work. Ultimately, he may be deprived of his right to vote, lose control of his property, or have jeopardized the legality of any marriage entered into subsequent to his certification as insane.

By and large, these actions are left to the discretion of the doctor and hospital administrators. As has already been noted, psychiatrists control, without the possibility of formal opposition or review, the determination of hospitalization and treatment. Although it is true that the patient comes into contact with lawyers, and is subject to legal procedures, it appears that the lawyer and judge are viewed primarily as adjuncts to the hospital administration or psychiatrist. They do not appear to consider themselves as adversaries of the state in commitment proceedings.

Legal Effects of Treatment Without Certification

Although being identified as a "mental patient" in the Soviet Union is not equivalent to being certified insane, it nonetheless has definite legal ramifications. There is, however, no procedure by which the change in status from ordinary citizen to mental patient is officially acknowledged. While hospitalization and in many cases outpatient treatment is sufficient to effect the change, it is not clear whether participation in limited treatment programs at a polyclinic, school, or workshop is enough to incur the label "mental patient."

In any event, the identified mental patient retains many of his rights. He continues to be covered under old age and disability insurance.[29] In addition, his right to education is preserved, and he may, while under treatment, enter a college or university, subject to the approval of the Ministry of Health.[30] Moreover, he will not lose his job, provided that his illness is regarded as recoverable, and he may, in addition receive preference in housing.[31]

On the other hand, if the patient marries there is a real possibility that the marriage will not be recognized. Russian law prohibits persons with serious mental illness from marrying, and on presentation of appropriate proof, the marriage will be annulled. But should his marriage be annulled, the patient

Delegation Headquarters, Vinnitsa.

may claim maintenance from the normal spouse, who must also provide for the children.[32] The law also places restrictions on the patient's right to control or dispose of his property. However, unless he is certified insane, the patient will be able to make most of the normal decisions regarding his affairs.

The Lawyer's Role Before Certification

To assist the patient and his family at the hospitalization or treatment stage, and to see that the state's interests are protected, each polyclinic and neuropsychiatric dispensary is staffed by two or three lawyers.[33] These lawyers help adjust pension seniority, social security and work rights, and assist in resolving any housing problems. In effect, these lawyers act as legal social workers. Their presence indicates the Russian emphasis on relieving a patient of the worries of managing his own affairs while he is under treatment. In a very real sense, in these circumstances, the lawyer is seen as part of the treatment process.

Unlike American lawyers, each Russian lawyer has some familiarity with the problems of the mentally ill. As earlier indicated, all Russian law students are required to take a course in forensic psychiatry. This course, given at one of the regional institutes of forensic psychiatry, affords the student an opportunity to see patients and psychiatrists and observe their interaction in the treatment process.

At the direction of the psychiatrists teaching the course, a textbook has been developed by the Ministry of Higher and Specialized Education. This volume,[34] which is one-third the size of the best American text—*Psychoanalysis, Psychiatry and the Law*[35]—reviews (a) general problems of court responsibility including questions of competency to stand trial, criminal responsibility, compulsory treatment and civil commitment procedures; (b) the foundation of general psychopathology, which includes a discussion of symptoms, their causes, and the diagnosis and treatment of mental illness; (c) the specific forms of mental illness and their medico-legal psychiatric evaluation.

The text is best described as a practical manual. Its greatest utility would seem to be as an aid to those attorneys who confront the problems of criminal responsibility and the more sophisticated problems of civil commitment such as certification or guardianship. It does not raise moral or philosophical questions. Nonetheless, the fact that lawyers are required to take such a course does insure a certain awareness and hopefully, sensitivity to the problems of the mentally ill.

The Certification of Incapacity

The Civil Code of the RSFSR provides that "a citizen may be declared incapable by the courts by the procedures laid down in the Civil Code . . . and placed under guardianship if, as a result of mental illness or weakness of mind, he cannot comprehend the meaning of his acts or control them." [36] Such certification has, obviously, implications beyond those attached to identification as a mental patient. A judgment on the person's ability to function has been made by the state, and control over his affairs has been transferred to a guardian.

The procedures for certification set out in the Civil Procedure Code of the RSFSR require the filing of a claim of incapacity.[37] Such a claim may be filed by a number of agents including the patient's family, his trade union or business organization, the procurator, the guardianship agency or the psychiatric facility at which he is being treated. The claim must discuss the circumstances which have led the agent seeking certification to suspect serious, and incapacitating, mental disorder. Upon receipt of the claim, the appropriate regional court must direct an expert examination of the patient. Following the forensic-psychiatric examination, a judicial hearing is held to determine the patient's capacity. The person in question, the procurator and a representative from the office of guardianship must be present, but there is no provision authorizing legal representation for the patient at this stage of the proceedings. However, if false statements have been made by the party seeking certification, costs for the entire procedure are recoverable from him. The RSFSR Family Code suggests that a certification decision of the commission can be appealed within a month "by all interested parties and institutions to the presidium of the corresponding executive committee." [38] Since the executive committee referred to is from the Ministry of Health it appears that this procedure provides no more than an administrative review. There is no evidence of any recourse from this committee to the courts.

The process of decertification can be initiated only by the agent who originally sought certification. Decertification restores the citizen to full civil capacity. Unlike certification, however, it can be achieved only after a full medical examination at a forensic psychiatric institute. It was the impression of the delegation that a much more vigorous investigation was necessary to establish a decertification than certification.

Legal Guardianship

Guardianship in the Soviet Union is used in at least two ways in dealing with the mentally ill. The first has already been discussed (See *Outpatient Treatment*) and is essentially a therapeutic manipulation where a patient is placed under the control of his, or another family. The second, formal legal guardianship, involves not unfamiliar determinations and administrative procedures to provide for the management of a citizen's affairs, once he has been declared by the court to have limited civil capacity.[39] However, in contrast to American procedures there is no court supervision of a guardian's appointment or activities. The case is turned over to a separate guardianship agency, a referral from which there seems to be no appeal.

The agency then appoints a guardian from those parties eligible to serve.[40] Parents or adoptive parents are deemed guardians even without formal appointment. Others selected as being qualified to serve as guardians must be appointed. Any guardian must come from the immediate area and (1) must not have been deprived of his voting rights or of his parental rights, (2) must not have interests contrary to the patient, (3) must have enjoyed good relations with the patient, and (4) must not be a minor. Since guardianship in the Soviet Union is considered a citizen's obligation, few people are permitted to decline an appointment. Only those who are over 60 years of age, are unable to perform the functions of a guardian, are bringing up two or more children, are nursing mothers or have children under 8 years of age are excused.

As in the United States, the duty of the guardian is to manage the affairs of the patient in the latter's best interests. The guardian does not receive any payment beyond expenses incurred in the administration of the patient's affairs. However, if the patient has income-producing property, the guardian is entitled to 10 percent of the income in addition to his expenses.

To insure the scrupulous handling of the patient's affairs, the guardian's actions are supervised by the Guardianship Agency which coordinates his work with the Ministry of Health. The guardian must present an annual report containing information about the patient's financial condition and the guardian's expenses, and penalties are imposed on those who abuse their trust.

Certification of a Patient's Inability to Work

The most extreme step in the commitment process is the determination that a patient who is certified cannot make any contribution to the state—*i.e.*, that in labor-short Russia, he is unable or partially unable to fulfill his obligation to work. Such determinations are made for many persons who are not mentally ill; in fact the mentally ill comprise only about 5 or 6 percent of the total invalid group in the Soviet Union.[41] The Russians have responded to the general problem of invalidism by setting up an administrative structure similar to that employed for certifications of insanity or determinations of criminal responsibility. As in the latter procedures, the focal point is an expert medical commission. The commission examines the invalid and considers what type of work his illness allows him to undertake. It then submits a report, apparently to a court, which seems to adopt the report automatically.[42]

There are two general categories of expert examinations. The first deals with a temporary incapacity and is handled by the patient's physician or psychiatrist through the Medical Control Commission in the treating institution. This commission is empowered to issue inability to work sheets, to change the conditions of work or to transfer individuals to less demanding work without a reduction of salary.[43]

The second type of commission deals only with "persistent inability to work" cases. These cases are examined by a Medical-Labor Examination Commission which works in the treating institution and is staffed by specialists who are familiar with the patient's problems. In the case of a mental patient the commission will consist of three physicians, two of whom are psychiatrists, and a therapist. The aim of the commission is to determine the extent to which the patient has lost the ability to work, to make recommendations regarding the kind of work for which the patient can be retrained, and to select the type of invalid home which best suits the patient's needs.[44]

The format of the expert examination is a clinical investigation of the particular patient at work. If necessary, a work situation will be simulated and the patient's capacity to function estimated. The decision of the commission is binding and there is no possibility of judicial review.

Issues of Relevance to U.S. Mental Health and Legal Professionals

In retrospect, three features of the Russians' approach to mental illness stand out as particularly relevant to psychiatry and the law in the U.S.: (1) the Soviet psychiatric attitude towards criminal responsibility, (2) the lack of judicial review in the process of civil commitment, and (3) the ability of the Soviet mental health system to intervene at an early stage and stay with a problem.

Soviet Psychiatric Attitude Toward Criminal Responsibility

During the visit, the delegation members were perplexed by the apparent inconsistency between the hard line taken by psychiatrists on the question of criminal responsibility and the impressive network of comprehensive mental health services provided for Soviet citizens. With such a large commitment to treatment and rehabilitation, how could Soviet psychiatry at the same time profess to deny that social and psychological factors could themselves be sufficient to excuse responsibility? Certainly the legal standard as expressed in the Fundamentals of Criminal Legislation and Criminal Court Procedure (See *The Present Standard*) and as implemented in the laws of the various Republics does not limit irresponsibility to organically caused mental illness. The 1961 R.S.F.S.R.* Criminal Code in fact defines nonimputability as the inability of a person "to realize the nature of his acts or to control them as a consequence of chronic mental illness, temporary derangement of mental activity, feeblemindedness or other diseased condition." Prerevolutionary Russian Criminal Law had virtually the same provision.[45] And as noted earlier, Soviet psychiatry in the 1920's and 30's did accept a broad psychosocial interpretation of irresponsibility.

In his study of justice in the U.S.S.R., Professor Berman notes at least one instance in which the court apparently adopted as a rule of Soviet law the more restricted psychiatric principle of irresponsibility stated by the Serbskii Institute.[46] Doubtless the subjection of psychiatric determinations to Court review beginning in the late 1930's contributed to the change in the psychiatric profession's interpretation. Whatever the reasons, at the time of the delegation's visit in 1967, Soviet psychiatrists generally accepted the narrow view as expressed by Dr. Lunts that "the state of irresponsibility denotes . . . a diseased alteration of the psyche, in which the behavior of the person as a whole is determined by the diseased-psychopathological factors . . ."[47]

Dr. Lunts goes so far as to argue that the very notion of "reduced respon-

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**Russian Soviet Federated Socialist Republic, the largest of the Republics and the one which includes Moscow.*

sibility" propounded by S. F. Semenov merely confuses the issue and detracts from efforts to determine whether there was or was not an organic abnormality.[48] To be excused from responsibility, then, means quite literally to be different in all ways—organically as well as psychologically and socially—and there is a cast of permanence to the label. It is thus an extreme measure, comparable to the certification of a patient's inability to work (See *Certification of a Patient's Inability to Work*). There is little leeway for either nonresponsibility or nonparticipation in the Soviet system. The basic assumption is that everyone must be responsible; the system commits a great many of its resources—legal, medical, vocational, etc.—to assure this expectation. It seldom gives up on an individual. From this emphasis it would seem that, more than under M'Naghten, the primary function of forensic psychiatry in the U.S.S.R. is to assure responsibility to the system (or legal order).

H. J. Berman, who over the years has studied the roles of Soviet psychiatry and law in determinations of imputability, describes their evolution in this way:

> *The role of punishment has been enhanced, that of 'treatment' reduced. The whole tendency has been away from individualization of disposition on a medical-psychiatric basis and toward an increasing extension of the category of 'responsibles.' The reason for this is the clue to the Soviet solution of both the substantive and the procedural problems raised by criminal nonresponsibility. Underlying the Soviet definitions and methods is the desire to maintain the mentally ill in the effective performance of their social roles and to keep them going, if possible, as normal persons. The purpose is not to promote the welfare of the individual, for his own sake, but to maintain his social productivity, in this sense to educate him, for society's sake. It is the task of the courts to make a deliberate choice of the means by which this may be achieved, within the legal standards established for the proper functioning of society as a whole.*[49]

The delegation could add from its own observations and study that Soviet psychiatry likewise seems to have made a deliberate choice of one of the means by which this may be achieved, i.e., by promoting a restricted view of nonimputability.

In the light of the foregoing, it is easier to reconcile the Soviet psychiatric attitude towards criminal responsibility with the impressive Soviet organization of mental health services. The whole system is geared to maximize responsibility and productivity. This purpose is served both by excusing few and by compulsorily treating many. Both prison and hospital are used to reinforce the ideal model of the responsible productive citizen.

But what the delegation still finds hard to understand is the insistence by the Russian psychiatrists that the Medico-Legal Commissions "make only medical judgments," and are not involved in the moral decision about whether a person should be held responsible for his acts. To what extent psychiatrists *should* make moral decisions of this nature is a hotly debated question, both in the United States and within the delegation itself. But it hardly seems debatable that the decision to hold a person responsible unless he has some organic disease or defect is a moral decision. Moreover, the Commission makes a specific recommendation as to imputability that goes far beyond the mere presentation of information about the health of the individual—a recommendation which the courts seldom, if ever, reject. Indeed, the Russian psychiatrists' involvement in the moral decision is if anything compounded by their insistence that they make "only medical judgments."

Lack of Judicial Review in the Civil Commitment Process

Given the use of lawyers in the mental health system, the delegation representative was puzzled by the failure to provide an appeal to the courts in the civil commitment process. Soviet law provides no judicial review of civil commitment practices. The Russians explain away this failure in several ways. They contend, first of all, that the health ministries keep a constant watch over the civil commitment system, to ensure that it is operating correctly. But no matter how good such internal administrative review may be, it is doubtful whether anyone in the United States would rely solely on the bureaucracy to police itself. They also argue that the patient's family, employer, union and party organization will protest if he is improperly committed. But, as noted previously, the family, employer, etc., are often the moving forces behind a commitment. Therefore they cannot invariably be relied upon to protect the patient. And even if they do protest a patient's commitment, there is no guarantee their protest will be heard or heeded.

Next, the Russians contend that judicial review is unnecessary because the psychiatrists have no motive to commit or detain a patient unjustifiably. But judicial review in this country is not premised on the belief that psy-

Judge Bazelon at the American Embassy, Moscow.

chiatrists will act in bad faith. It is predicated on the belief that even the most conscientious and well-meaning psychiatrist will sometimes depart from legal and medical standards.

Judicial review of departures from *legal* standards in the U.S. create few misunderstandings between psychiatrists and courts. Everyone agrees that it is the duty of the courts to see that these standards are followed. Judicial review of departures from *medical* standards, however, creates serious misunderstandings. Many psychiatrists believe that the court is intruding where it doesn't belong, that it is trying to set medical standards and tell experts how to practice their profession. But in right to treatment cases, like malpractice cases, the court is not setting medical standards. It does not pretend to know more about the doctor's field of medicine than the doctor himself. All the court is doing is providing a forum where the doctor's practices can be examined and appraised by other experts in his field of medicine. In malpractice and right to treatment cases, the issue is whether the doctor has adhered to the commonly accepted standards of his profession. The court relies upon other doctors, not its own wisdom, to determine these standards. In the final analysis, therefore, the medical community is judging itself.

The foregoing is not intended to suggest that the court's role is merely mechanical. Experts often differ among themselves; they do not all agree, for example, on what constitutes "adequate treatment." And when doctors disagree the court is forced to weigh competing theories in order to reach a judgment. But even in these cases the court is not imposing a standard from the outside; it is acting within the boundaries set by the medical profession itself. If the profession had a universally accepted standard, the courts would be happy to apply it. Since the profession does not, the courts must choose the one which, according to the experts' submissions, appears to have most support in experience and logic.

Judicial review also enables society as a whole to learn how its mental health system is operating. We would know a great deal more about the Soviet system if there were published reports of court cases. The absence of judicial review in the Soviet Union may reflect a belief that there is no need for the public at large to oversee government officials and ensure that they respect all substantive and procedural rights. Americans would have some difficulty with such a notion. We do not share this faith with respect to our government officials, whether they are experts in mental health or aeronautics or communications.

Early Intervention and Continuity of Soviet Mental Health Services

Whatever his reservations about the lack of legal safeguards, the delegation representative was impressed with many aspects of the Soviet mental health system. Particularly striking is the system's ability to intervene at an early stage and stay with a health problem. It carefully monitors family, educational, and work institutions through a wide range of contact points. For example, because the Russians are deeply concerned with speech defects and the attendant emotional problems, their schools have an elaborate speech therapy program.

The outpatient program, discussed elsewhere in this report, is equally impressive. Of course its effectiveness depends in large part on the fact that the all-pervasive government can commandeer jobs, apartments, etc., for the patient. We should bear in mind, however, that our government could do a great deal to provide similar benefits. For example, it could employ outpatients, or subsidize employers who do. It could provide rent subsidies to families who care for outpatients. When we truly decide that mentally ill people are to be brought back to society and not dismissed from society, we will find that many flexible avenues of treatment exist. The task of lawyers and psychiatrists is to hasten the arrival of that day by educating the public, by encouraging and fashioning facilitating legislation, and by experimenting, on as large a scale as possible, with new programs of treatment and care.

To promote a comprehensive health care system, the Russians publicize the availability of services and, more importantly, stress the obligation of the citizen to conform to society's expectation that he will seek treatment so that he may function usefully as a citizen. Indeed, as elaborated in the comments on criminal responsibility and the specific references to Berman's analysis, the whole health care system is focused on reinforcing the individual's value to the state by getting him back to work. Certainly the variety of services made available for this purpose is impressive. But, at the same time, the assumption that the state has the right to intervene in the lives of its citizens to make virtually all of the decisions on health care is troublesome. The Soviet system, for all its accomplishments in fashioning a comprehensive network of health services, depends upon and reinforces a social system which is difficult for an American to accept.

However, American medical care raises similar problems, albeit to a lesser degree. Americans must examine the extent to which government or medical experts should be permitted to decide what is best for the individual—the extent to which expert decisions should be reviewed by courts, agencies and legislatures. The Russian trip did not provide the answers to these questions. But it did suggest the need to re-evaluate the ends American lawyers and psychiatrists are trying to achieve and the means they have grown to accept.

PART III

Mental Health Facilities

Notes on Adult Facilities Visited

MOSCOW

Kaschenko Mental Hospital

One of the largest hospitals in Russia, Kaschenko has 2,600 beds and serves five districts of Moscow which have a population of approximately 2 million people. Because of its size and its significance as an example of the importance of specialized mental hospitals in the mental health care system of the U.S.S.R., the delegation paid visits to this facility on two consecutive days.

Observations and Impressions: First Day

The entrance to Kaschenko Hospital is marked by an open gateway. Along the tree-shaded roadways there are signs bearing the building plan in diagram so that one may find his way to a particular building on the spacious grounds. Buildings are not arranged in formal campus manner but scattered over the area and have many different styles of architecture. Some of the buildings have an outdoor area enclosed by an eight-foot high walled enclosure; others have a fence similarly constructed but with vertical cement columns. New trees have been planted along the streets. There is no formal landscaping of lawns or flower beds in the English hospital style and the grass is uncut.

Patients relaxing in the sun were well-dressed, seemed quite self-reliant and capable of managing themselves. Some patients dressed in blue denims were playing games in an enclosed court. There was little evidence in the area of lawn furniture or recreational equipment.

The wards were spotlessly clean and newly painted. The design of buildings was linear with a central connecting corridor and enclosed stairwell. The link between the two lateral wards on a floor was used as a visiting room. This is followed by a ward day hall on each side, a series of nine-bed dormitories, a dining area with tables that seat four, and at the ends of the ward were bathroom and toilets.

Ward Staffing

There is one doctor to each 25 acutely ill patients, and one to 40 chronic patients. On the floor that housed 96 patients, the charge doctor—a woman—had two physician-assistants and eleven physicians assigned from the research institute to serve on the ward. Nursing for 65 patients totalled 28 individuals on five duty tours in a day, so that there were not less than five or six nurses on duty at one time. Doctors wore white coats; the nurses, all women, wore white wrap-around uniforms and a white bucket cap that pulled down over the hair.

Patients

About 40 women entered an empty ward at noontime while we were there. They had all been working in the morning in the occupational therapy shop. All were dressed as were women in the city. The patients seemed at ease, there was no tension, no disturbance, the interaction with nurses was free, and there was an exuberant greeting of Dr. Maya Shchirina a member of our party. On the disturbed ward there were four or five female patients in bed with a nurse in attendance. One of the patients was reading a newspaper; others were watching us with curiosity, but none of the patients was aggressive or in need of relating complaints to a physician.

Facilities

We were told that it was policy to make major repairs of each building every five years and minor repairs, including painting, every two years. In the day hall on the ward there were sofas and chairs, tables, radio, TV, plants, flowers in vases, colorful draperies, and everything was tidy and shined. The day hall for the chronic, disturbed ward was locked away from the center unit and from the ward unit as well. On two other wards on another floor, both were open to the connecting central link. The dining areas had eight tables of four—the tables were light in construction, and were highly polished. Food was served from a window leading into a small ward serving kitchen. The food was brought in containers from a central kitchen. (We were later to visit some of the kitchens and found they had good equipment.)

Patients' rooms were in nine-bed dormitories, five or six of them per ward. There is a space of about two feet between the beds—iron cots painted white; mattresses were thin and somewhat sagging; there were a few bedside tables with flowers, no lockers or individual space for possessions, and no chairs at bedsides. Spreads were available and blankets were in "packets"

Entrance to one of the Kaschenko Hospital buildings.

like those in our hotel. Bathrooms were tiled, and there were three bathtubs on the ward.

Clothing

No clothing lockers or clothing rooms were on the wards. We were told that when occupants of the building bathed, they drew clean clothing from the central clothing room in the basement. Sizes were approximate in this system. Most patients do not have their own personally laundered, marked clothing, and there were no facilities on wards for patients to do personal laundry.

Treatment Room

The treatment room was white-tiled with an examining table and appropriate instrument cabinets containing the usual equipment. There was evidence of a nurse's order system. The nurse's office was located in a room off the central corridor. It contained a cabinet for the dispensing and issuing of drugs. There were individual medicine glasses and medication cards for each patient. (We noted a smaller variety of available drugs, including tranquilizers and anti-depressants than is customary in a U.S. hospital ward drug cabinet.) Other offices used by staff are located in the central connecting link between two linear wards and their day halls.

The occupational therapy space on the ward consisted of three tables where patients were doing sewing, embroidery work, making pin cushions, towels, spreads, and scarves.

The ward classification, we noted, was based on the patient's social behavior; if he did not conform, he was transferred to another ward where patients suffered from behavior disturbances like his own.

We had lunch in the office of Professor Snezhnevsky, where a picture of Ernest Hemingway was hanging on the wall.

Second Day

Kaschenko Hospital shares its resources with the Institute of Psychiatry in Moscow and the unimposing entrance to the Institute building fails to suggest its importance. The lobby is dominated by a huge statue of Kaschenko and a central marble stairway, up which the delegation proceeded to the office of the Director, Dr. B. M. Morkovkin.

Speaking from prepared notes, the Director informed us that the hospital was established in 1894 as a public charitable institution with beds for 500 patients. It was originally named for Alexayve, a local official, who was murdered by a patient on the day of the hospital's dedication. In 1925, its name was changed to the present one in honor of a progressive hospital director who served from 1900 to 1905.

Kaschenko is located on 75 acres of landscaped grounds. We were told that there were 14,000–16,000 admissions to Kaschenko a year, indicating that the average bed is used by approximately six patients per year.

For this population, the hospital had a staff of 200 physicians of which 160 were psychiatrists. There were also 800 nurses and 1,100 ward orderlies. The staff also included some 500 auxiliaries who served either as attendants or provided janitorial or other services. All told, there were

2,600 staff for the 2,545 patients in residence at the time of the delegation's visit.

Touring the Wards

There are forty wards in the Kaschenko hospital for acute, relapsed, geriatric and chronic patients. These wards are located in various buildings and range in size from sixty-five to ninety beds each.

Admissions Ward

The Admissions unit was located in a separate building. There was a bare waiting room, stripped of furniture except for heavy wooden benches that, it was explained, "could not be thrown by disturbed patients." The physician's office was sparsely furnished, with an unusually heavy chair for the patient to sit in. There was also a disrobing and weighing room and a tub bathroom, where all patients were given a bath on admission. The delegation was told that patients had the option of wearing either their clothing or hospital clothes but the hospital had no ward laundry facilities

A nurse standing by the unlocked door of a former seclusion room at Kaschenko Mental Hospital.

and there did not appear to be arrangements for the laundering of an individual's personal clothing.

Placement on the admissions ward is temporary and depending on the patient's condition, he will be transferred to one of the other wards of the hospital. In contrast to the starkness of the admissions unit, the atmosphere on these latter wards was pleasant and attractive.

Ward for Male Chronics

The approach to this ward was in sharp contrast to the admissions unit. Paved courtyards bordered with flowers, and groves of trees marked the path. The center of the building was used as a day hall for the patients, or for interviewing purposes. While the wards themselves were clean and attractive, there was evidence of overcrowding. Beds were placed in the corridors leading to the wards and there were often ten to twelve beds in rooms that had been designed for eight patients. In a former seclusion room, the delegation noted four beds.

Despite this overcrowding, however, the atmosphere on the ward was quite pleasant. Patients seemed well cared for, and there was an abundance of staff, particularly nurses.

Suicide Ward

The delegation passed through a so-called suicide ward for eight female patients. Although these patients were deeply depressed, the door to the hallway was open and there were no bars on the window. We were told that security glass provided the necessary protection. There were three nurses in the room and one of them was sitting on the bed comforting and reassuring an obviously distressed patient.

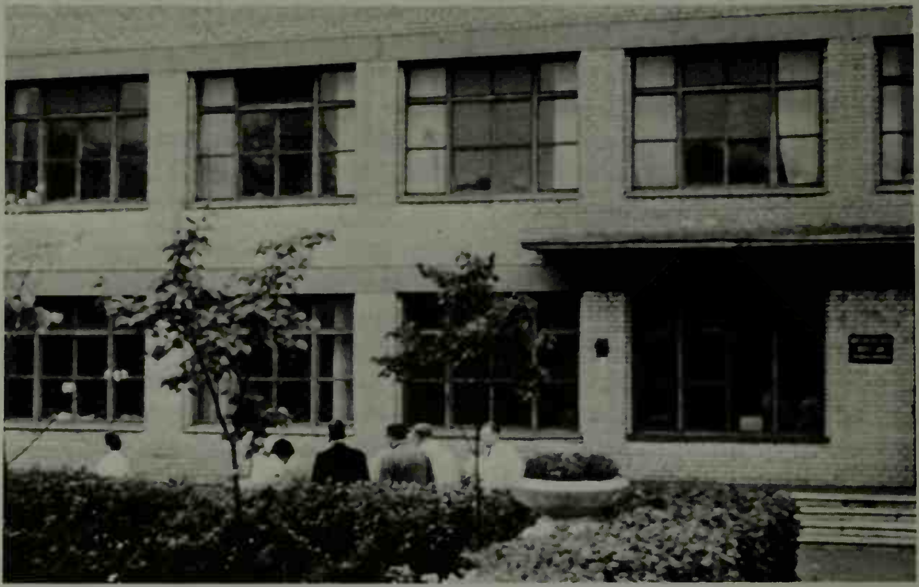
Geriatric Wards

The delegation was told that 20% of the hospital population consisted of patients over the age of 65. Two buildings with a total of nine wards were devoted to the care of these patients. Patients in these wards were well-dressed, similar to elderly people in the community.

Corridors were spotlessly cleaned and polished with tables holding freshly cut flowers. The furnishings in the rooms were on a par with those the delegation had observed in apartments in the community.

Convalescent Ward

This ward was for patients who had been transferred from one of the acute wards, and were soon to be discharged. It was easily the most spacious and luxuriously furnished ward of the hospital. Corridors were furnished with attractive inlaid furniture, lamps with sculptured bases, and vases that could well have been placed in museums. Many of these pieces, it was the delegation's understanding, came from the various private estates that existed prior to the Russian revolution. The library and day hall were equivalently furnished, and the latter room had a grand piano and television as well. While individual rooms were not as lavishly furnished, they were certainly adequate. There was sufficient space between beds and a chair and cupboard for personal possessions were allotted to each patient.



The workshop building at Kaschenko Hospital.

Workshops

The workshops at Kaschenko were located in three two-story buildings. At the time of our visit there were approximately 500 patients. While most of them were busily working, the delegation observed a number of patients sitting idly by or watching the other patients. Women were engaged in sewing towels, making artificial flowers, machine sewing linens for hotels and hospitals, as well as making boxes, envelopes and labels. Men were working in the shoe factory, and were making boxes for chess games, drugs and candy. Others were helping in the construction of mattresses and some heavy machine work was going on in the wood shop.

Although the day hospital concept as such is not very well developed in the Soviet Union, many of the workshops were operated in a manner similar to day hospitals. That is, in addition to the standard workshop activity, there were also opportunities for various recreational activities such as billiards, painting and other handicrafts. The workshop, however, was primarily a therapeutic facility and drugs were readily administered to the outpatient workers. In addition, a number of beds were always available for those patients for whom rest was considered necessary.

Treatments

The range of treatments available at Kaschenko included the standard Russian armementarium. In addition to the workshops and chemotherapy, there were reported to be individual and group psychotherapy, and individual and group hypnosis. Sleep therapy, once quite popular, is now rarely used. In addition, on one female ward, the delegation noted 10 patients receiving coma or pre-coma insulin therapy.

Dr. H. C. Masliaeva, Deputy, and Dr. B. M. Morkovkin, Director of Kaschenko Hospital, with Dr. Yolles and Mr. Gorman.

Impressions

Generally speaking, there was consensus that Kaschenko was a first-rate facility. There was no question that the vigor and activity inside the hospital quickly and decisively overshadowed the first impression of an old and shabby installation. An air of therapeutic optimism was everywhere apparent and the abundance of professional staff made individual patient attention a reality. What was particularly interesting was that the cost per patient of this program was not appreciably different from that of the average state mental hospital in the United States. While it is difficult to obtain exact figures, the daily patient cost at Kaschenko averages out to seven rubles, only slightly below the 1967 American figure of $8.44.

At luncheon with the Superintendent of Kaschenko, one of his visitors asked him what he wanted most for his hospital and for the patients. His reply was quick and direct. "I want most," he said, "to be able to treat schizophrenia.

A reply of this kind is most revealing. In all our time in Russia, the delegation heard none of the alleged denial of mental illness by Russian authorities. On the contrary, they were not only very frank to admit its existence, but they seemed willing to agree that incidence, in Russia, was comparable to that in the rest of the world and that they, too, were still searching for successful treatment of schizophrenia.

Polyclinic #77, Dherzinsky Ryon

Dherzinsky ryon serves a population of some 40,000 people. The structure of the district—and thus, the organization of health services—is a typical one. Dherzinsky ryon is divided up into 13 microdistricts (uchastoks) which serve a population of approximately 3,000 persons each. For each microdistrict there is an assigned physician, and either a nurse or feldsher, with offices located at the district polyclinic. Thus, polyclinic #77, as its equivalent polyclinics throughout the Soviet Union, becomes the hub for general medical activity within the district.

For the population covered, polyclinic #77 had a staff of 86.5 physicians and 122 paramedical workers. (Fractional figures are the result of staff working additional half-shifts.) Further, there were reported to be 60 auxiliary workers, including maids, orderlies, secretaries, janitors and so on.

Physicians are on duty at the polyclinic from 8:00 a.m. to 9:00 p.m. However, this represents two working shifts a day. A physician working a single shift averages 6½ hours a day, with 3½ hours spent seeing patients at the clinic and 3 hours involved in home visits. After 9:00 p.m. the central emergency system responds to medical calls, although polyclinic #77 does have ambulances available for daytime emergency service.

In addition to the general practitioners located at the polyclinic there were also a number of specialists. Included in these were a urologist, opthamologist, ENT, a dentist and a stomatologist. (Dentists have 3½ years of training and are limited only to filling teeth. Stomatologists who undergo a five year training program may perform surgery.)

Patients may choose to see their uchastok physician or, if they have "diagnosed" their condition, one of the specialists. In any case, referral is no problem inasmuch as all physicians are located in the same building. In addition, there are two small industrial units within the ryon, each with small medical units, and patients working in these facilities have the option of receiving their medical care at work.

Laboratories at the polyclinic perform routine clinical tests. X-ray and fluoroscopic examinations are standard and each patient who has received such an examination is reminded to return for an annual check-up. Screening and follow-up activity is an essential part of the polyclinic's operation and, indeed, of the health network in general. Industrial health centers provide annual physical examinations for their workers and children and teenagers are medically screened in the schools. The principal problem in screening involves retired workers, nonworking housewives and pre-school children. Through a process of home visits, however, contact is maintained with many of these people. At the record room of polyclinic #77, for example, there were 30,000 cards on file for the 40,000 persons living in the district.

Although the polyclinic is the focus of outpatient medical care in the district, it is by no means the only such facility. There are, for example, separate gynocological centers for women over 30, with special emphasis on the detection of cancer.

Despite the concern with early identification and screening of medical problems, it was the delegation's impression that there was no examination for neuropsychiatric disorders. However, it was pointed out by the dispensary staff that the general physician and nurse are able to recognize mental abnormality, and on their home visits can evaluate a patient's mental status. If specialized psychiatric care is necessary, the patient can be referred to the neuropsychiatric dispensary. Similarly, while there is no specific screening for mental retardation by the polyclinic staff, retarded children can be identified either at the school or at the maternal or child welfare units.

Although it was reported that there was a neurologist on the staff of polyclinic #77, it was indicated that he ordinarily did not handle cases of severe mental illness. As in other situations, when mental disturbance was identified, it was followed by the patient's referral to the neuropsychiatric dispensary.

The liaison between the dispensary and polyclinic #77 seemed particularly good. Inasmuch as the dispensary provided the specialized treatments necessary, the polyclinic limited its role to the screening and detection of mental patients, with some limited treatment. This treatment was usually reserved for those patients with somatic complaints masking their emotional disorder. It was reported that these patients would be treated for relief of their symptoms for two or three years; if that failed, they would be referred to the dispensary for more intensive treatment.

This system of referral was perhaps the most striking feature of polyclinic #77's operation. When a patient is referred to another medical facility, the patient's records accompany him. If he is seen for example at the factory health unit instead of the polyclinic, the former unit has the responsibility of notifying the polyclinic of the patient's condition and the action taken. Should a patient be referred to the NP dispensary and not go, this information is communicated to the dispensary and, in all likelihood, a psychiatrist will visit the patient's home.

Facilities at the Polyclinic

Generally speaking, the delegation found the facilities at the polyclinic to be adequate. There was a small conference room with space for about thirty people, an admission office, an X-ray and dental department with a common waiting room and a number of offices.

The therapeutic section included individual offices for the surgeon, internist, and EKG examination. On another floor, an internist was performing the mandatory complete physical examination for automobile drivers. This was not only an initial examination, but was repeated every five years.

The delegation also noted complete physical therapy facilities, a room with medical gymnastic equipment and a nurse-masseuse on duty. It was reported that this nurse also made home visits and gave treatment there. An unusual unit housed the equipment for inhalation therapy, used for patients with asthma and chronic bronchitis. There was also a hydrotherapy room, but it was the delegation's impression that hydrotherapy, like sleep therapy, was not much used by the younger physicians.

Neuropsychiatric Dispensary

As the delegation visited the various types of facilities within the health care program of the Soviet Union, the relationship of each type to the continuity of care provided patients became evident and the NP dispensaries proved to be significant points of entry into the treatment program for many patients.

The NP dispensary that we visited in Moscow is one of 19 in the city. Distributed so that each of Moscow's 17 ryons has at least one dispensary, each is related to and collaborates with one of Moscow's 15 mental hospitals—in this instance, with the Kaschenko Mental Hospital.

The program here was illustrative of several characteristics of the ways in which the treatment program is designed to keep patients functioning within the community. Referrals between the NP dispensary and the hospital, for example, can be initiated by either facility, or a patient can be referred from his polyclinic, or because he or his family requests treatment for him.

These are close, working relationships. If a patient is referred from Kaschenko, a summary of his case is sent from the hospital to the NP dispensary within one hour after he leaves the hospital and he is expected to visit the dispensary within 10 days. If he does not, a nurse or one of the doctors will call on him at home. When a patient is referred *from* the dispensary to the hospital, the dispensary doctor attends a hospital conference; if there is disagreement concerning the diagnosis or disposition of the case, there is always another conference to resolve differences.

It was also evident that the dispensary staff has responsibilities toward patients which go beyond psychiatric therapy. Since there is no profession of social work in the Soviet Union, the dispensary physicians take social histories, make home visits and work to solve their patients' social problems. If a patient cannot care for his own affairs, a committee for guardianship does so. When a family cannot care for a patient, the NP dispensary staff has at its disposal a number of apartments (one hundred for this dispensary) and may assign patients to them. Priority in housing may be given a mental patient with a family, if that will assist in his treatment.

It was everywhere apparent that the Russian emphasis on work as therapy was central to treatment programs for the mentally ill. At the Moscow NP dispensary visited by our delegation, the facility included two major services: office treatment for its outpatients and workshops, located in a separate building, in a residential neighborhood.

Patients in the workshops arrive at 9 a.m., have a free lunch and go home at 3 p.m. When they acquire a skill and their work habits improve sufficiently to be acceptable in the community, patients can be placed in a regular job in industry. On the day of our visit, the workshops were crowded and active. A doctor was in complete charge of the workshop, assisted by a nurse supervisor. Patients were making the string shopping bags carried by all Moscow shoppers and produced by the government industry located entirely in psychiatric facilities. As other patients worked at power sewing machines, or made pockets for billiard tables, a phonograph was providing background music and pictures on the walls showed scenes from outings to theaters, museums and mushroom hunts. The atmosphere was reminiscent of a patients' social center in the United States and it was obvious that patients and staff were fond of the NP dispensary director—a blond, 40-year-old woman doctor—and admired her enthusiasm for program improvement and efficiency of operation.

Efficiency would indeed be necessary to handle the caseload reported to us. This dispensary reported 105,000 patient visits in 1966, which, of course, included multiple contacts with individual patients. Twelve thousand residents of the ryon were registered at the dispensary (2.4 percent of the population of the district), with 1,500 new patients registered each year.

The staff included 27.5 psychiatrists (personnel sometimes work additional half or full shifts), of whom 11 were child psychiatrists. This dispensary included a large children's clientele with services similar to those described in other children's facilities which we visited. Additionally, the staff included 35.5 nurses, 11 orderlies and 77 workshop personnel. The typical workday is 5½ hours, recently reduced from six.

The workshop budget was reported to be 130,000 rubles a year, of which 29,000 rubles were spent on medication. Its director proudly reported that in the first eight months of 1967, the workshop had reported a profit of 24,000 rubles. Part of this was paid the patients as salary, while the remainder was used to purchase food, TV sets and recreational equipment, and a portion was to be used to help finance a new workshop building. We were told that in addition to funds collected from workshop operations, the government provided a 25,000 ruble subsidy.

The children's section—a separate unit—was staffed by ten nurses and 11 speech therapists, as well as the 11 psychiatrists. The professional day was divided between patient treatment and home-consultation visits. Much time was spent visiting the nurseries, kindergartens and schools of the area, particularly the classes for disturbed children. It was reported that there was a wide variety of facilities for children in Moscow, including special nurseries for children with organic brain damage and/or speech defects. There were also two schools for mentally retarded children and a sanitarium for neurotic children.

The treatments available at the dispensary included the usual range—chemotherapy, directed activity, little-used sleep therapy and to a limited degree, psychotherapy. The delegation was told there was a psychotherapist on the staff and we had the opportunity to talk with him. He indicated that he was handling approximately 20 patients a week, most of them neurotics. Most patients, he said, were seen three times a week for sessions, usually of a half hour's duration, but sometimes extending to an hour and a half. The average length of therapy was from six weeks to four months and the emphasis was on redirecting and reconditioning the patient's attitudes toward his life and work. There was also a limited amount of group therapy wherein 20 or so patients discussed their problems under the leadership and guidance of a physician, and on occasion, there was some use of psychodrama.

The narcologist, whose professional concern was the treatment of alcoholism and drug addiction, was almost solely concerned with alcoholics. Addictive drugs are not readily available in the Soviet Union, and it was reported that addiction is not a serious problem. As has been previously indicated, however, alcoholism is so regarded and there were 2,800 alcoholics registered at the dispensary—nearly 25 percent of the total patient load. It was readily admitted, however, that treatment of the alcoholic was not particularly effective.

The delegation's impressions, in summary, were that there was maximum involvement of staff with patients, a liberal use of drugs, and much advice, direction and support. Although we were unable to substantiate the point, it appeared that there could have been somewhat greater collaboration with the area polyclinics, particularly in regard to screening and identifying those mental patients who were exhibiting less than major symptomatology.

Mental Hospital #14, Ramenskoy Village

The visit to Mental Hospital #14 came as a result of the delegation's request to see a work colony. The Russians said that there were no longer work colonies, but that Mental Hospital #14 had previously been a work colony and had been converted to a hospital under the jurisdiction of the Ministry of Health in 1965. It is now one of the 20 rural hospitals serving some 5 million people in the Moscow oblast. These rural hospitals range in size from 200 to 2,000 beds, with Mental Hospital #14 having 875 beds.

Ramenskoy is a small village located to the northwest of Moscow. The drive, through picturesque countryside, lasted almost three hours. The road ended at a river which was crossed by a small ferry. It appeared that the whole village had turned out to greet the delegation and it was reported that the villagers had never seen Americans before.

There are actually three units in Mental Hospital #14. One of these is the original work colony caring for those patients who remained after the administrative transfer. Some four miles away there are two additional buildings housing the acute unit and the area neuropsychiatric dispensary.

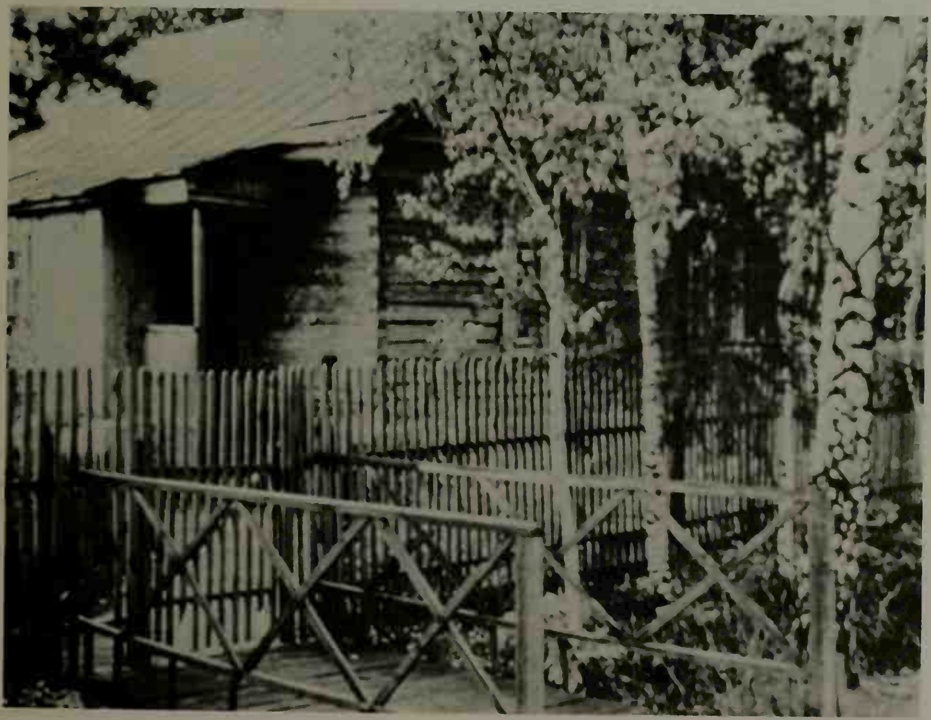
The buildings visited by the delegation were on both sides of a rutted country lane, lined with birch trees. The administration building was a small yellow building surounded by staff housing of rough hewn logs. A brick dormitory for nurses was under construction, and at the time of the delegation's visit trenches were being dug for the installation of a central heating unit.

White birches line the dirt road at Mental Hospital #14 at Ramenskoy Village.

The admissions building was constructed of white cement and though new, was shabbily put together. It included a number of physicians' offices, a conference room and a pharmacy with a limited number of drugs. The director of the hospital, Dr. Shelkovsky, indicated that, although all treatment modalities were in use at the hospital, the most important of these was directed activity. He particularly stressed the value of farm work, and pointed to the 1,000-acre farm attached to the hospital. He also seemed quite proud of the workshops for carpentry, tailoring, shoemaking, etc.

Recreational activity was also regarded as important at the hospital. The delegation was shown a theater constructed of logs and a small stadium for athletic events. Movies were shown three times a week and it was reported there was a patients' club responsible for the planning of picnics and other recreational activities.

One of the wards visited was an L-shaped, log-constructed building. It housed 75 patients which was about ten percent above rated capacity. In one dormitory there were 22 beds with only a few inches separating one from another. The delegation was told, however, that a new building was being constructed to help relieve the overcrowding. Although the hospital was not so well staffed as some of the urban facilities visited by the delegation, there were no shortages of staff. For the 75 patients on the ward there were two physicians, 11 nurses and 30 ward maids and orderlies. As the delegation walked down the hall, they observed a nurse standing in the doorway of every room; in many cases, there was an additional nurse inside the room.



A wooden ward building at Mental Hospital #14.

Despite the poor construction of the building, the interiors were furnished in the rather pleasant, standard fashion that the delegation had grown accustomed to. While not luxurious, the accommodations in this remote rural hospital were certainly adequate.

In another building visited there were 100 female patients. This building too, was overcrowded, but there were no shortages of staff. For the population there were three physicians, 20 nurses and 35 ward maids.

The delegation also visited the workshop building. Like most of the other buildings it was of rough, wooden construction and consisted of shops opening off a central corridor. There were about 90 patients at work performing the typical workshop activities. Included in this group were some very de-

New construction (right) is an addition to staff quarters at Ramenskoy.

Administration Building, Mental Hospital #14 at Ramenskoy Village.

teriorated chronic patients, but it was interesting to note that all were working.

The delegation then toured the most remote section of the hospital grounds. To reach this area is was necessary to travel twisting dirt roads cutting through heavily forested land. The ward buildings constructed of logs with corrugated iron roofs were quite primitive. Rough-hewn fences and carved window decorations gave the area the touch of a stage set. Apparently because of sensitivity concerning the primitive quality of the buildings, the delegation was not allowed to take photographs. However the delegation did not find the buildings objectionable. While their building interiors were not as colorful as those of the parent hospital, they were equally as clean and made as attractive as possible through the use of flowers and plants. More importantly, the program was quite the same as in the rest of the hospital.

At the time of the visit, patients were in bed for their rest period. At one end of the ward, however, a group of women was engaged in sewing. They were dressed in colorful cotton print dresses with the expected babushkas on their heads. On the wall, the patient's daily schedule was posted. The patients were awakened at 7:30 a.m. with breakfast scheduled at 8:00. Work from 9:00 a.m. to 1:00 p.m. was followed by lunch with another work period scheduled from 2:00 p.m. to 5:00 p.m. Dinner and recreational activities rounded out the day with bedtime scheduled at 10:00 p.m.

After the tour of the hospital the delegation lunched with the director and his staff. It was pointed out that despite all the hospital's efforts there were still patients too ill to benefit from an active regimen; these patients would have to be sent to a Home for Invalids. The goal, however, was to keep that percentage to a minimum. His comment, previously reported, is worth repeating.

"I do not," he said, "believe in chronicity. Much of the chronicity at this hospital has been inherited—it is the result of these past years of custody. I have been working with chronic patients for the last 14 years and I believe they are happiest when they are active. I intend to devote the rest of my life fighting the dragon of chronicity."

Polyclinic and Medical Service, Likhachov Motor Factory

The Likhachov motor plant is one of the largest factories in the Soviet Union with a work force of approximately 70,000 persons. It is here that the ZIL, the official Russian automobile, is produced, as well as trucks, refrigerators and other hard goods.

The polyclinic at the factory has 16 medical departments, including, though not limited to, internal medicine, dermatology, surgery, gynecology, orthorhinolaryngology, dentistry and oral surgery as well as departments for X-ray and fluorograph, first aid, traumatic surgery, functional diagnosis and a variety of laboratories.

Additionally, the polyclinic operates its own in-patient department, a TB sanitarium of 100 beds, a special dining hall for those with dietary problems, and 22 smaller medical units scattered throughout the factory to provide emergency service.

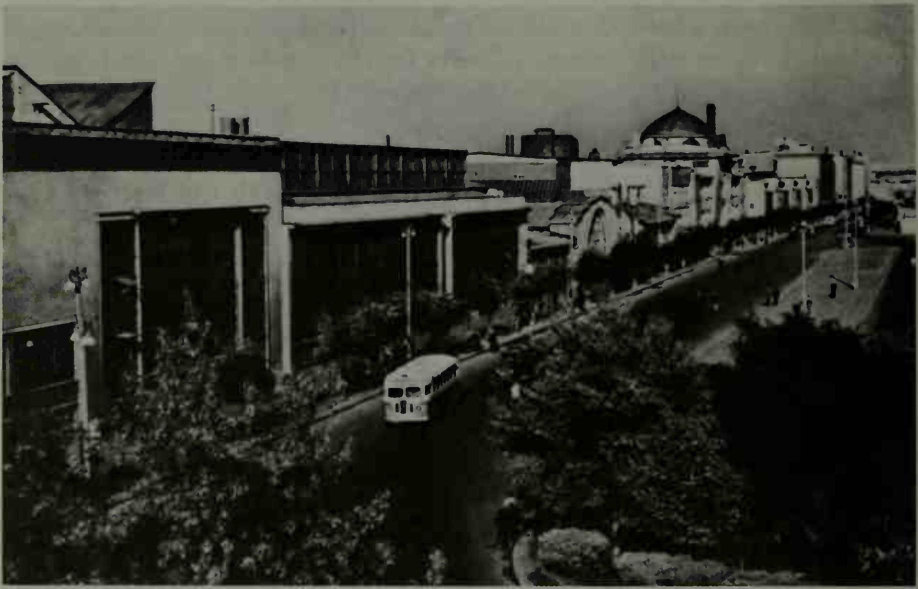
To operate a program of such magnitude, the polyclinic is very well staffed. At the time of the delegation's visit there were more than 600 medical personnel including 150 physicians and more than 250 paramedical personnel. On a typical day, there were reported to be more than 2,600 patient visits.

While the polyclinic physicians are themselves well trained, there is consultation available from a number of prestigious research institutes, including the Institute of Therapy of the Academy of Medical Sciences, the Institute of Industrial Hygiene and Occupational Diseases, the Institute of Traumatology and Orthopedics and so on.

All workers at the factory must receive an annual fluoroscopic examination. There is a special occupational pathology department whose responsibility it is to examine and maintain contact with the 12,000 workers who hold hazardous jobs; that is, those workers who have contact with dangerous chemicals or toxic products, or those who are subject to excessive noise or vibration and these workers are examined twice yearly. Additionally, there is an adolescent unit, under the supervision of a pediatrician, with responsibility for examining all teenagers working at the plant.

Although it was the delegation's impression that there was not any special screening for emotional disorder, the polyclinic did have a psychiatry department staffed by two full-time psychiatrists, with an average of 30 patient visits a day. There were no psychiatric beds, however, and if specialized care is needed, the worker will be referred to the neuropsychiatric dispensary or mental hospital. There were also nine neurologists on the staff who handled many cases of organic disorder.

The delegation was particularly impressed by the fact that there did not appear to be the usual stigma regarding mental illness among the workers. In fact, we were told that former mental patients were well supported by



The ZIL motor car factory in Moscow.

their fellow workers and that records were kept identifying those workers needing special emotional support.

A major problem at the factory seemed to be alcoholism. There is a narcologist on the polyclinic staff whose specialty is the treatment of and rehabilitation of alcoholics, but he also spends a good deal of time checking on the job performance of the alcoholic worker. A particular problem seems to be the detection of alcoholism, since most workers, if they drink, will attempt to hide this fact from the authorities.

It was the delegation's distinct impression—based on their visit to this factory—that the Russians place a high priority on the provision of top quality medical care to the worker. This was further reflected by the fact that although the medical facilities and equipment were generally creditable and, in some cases, superior, the delegation was told that the trade union committee of the factory had recently recommended that a new 1,100-bed hospital unit be built at the cost of some 8 million rubles.

Home for Invalids

Throughout the tour the delegation had made clear our desire to visit a facility for chronically ill mental patients. The visit to this Home for Invalids in an outlying district of Moscow was to fulfill that objective. It was with considerable consternation that the delegation realized that the facility we were visiting was a general Home of Invalids, and not specialized for mental patients.

The Home was located in a tall building indistinguishable from the other buildings of the area. A number of old people from the Home were sitting on benches outside the building and were mistakenly taken by the delegation to be residents of the area.

The Deputy Chief of Moscow's Social Welfare Department, Dr. Ladukhin, indicated that there were seventeen Homes for Invalids in the Moscow area. Of these, three were devoted to the care of chronic mental patients (psychochronics), three to the care of mentally retarded children and the remainder being classified as general homes for the care of the aged and invalid. Although nearly half the Homes were located in the rural areas of the Moscow oblast, it was pointed out that they exclusively served the city of Moscow.

Of the 7,000 beds in the Invalid Homes, approximately 1,300 were occupied by psycho-chronics, 1,500 by mental retardates, of which some 850 were children, and the remainder by general invalids.

The Home had 665 beds, 400 of which were for ambulatory patients with the remainder being devoted to the care of infirmary patients. It is interesting to note that 85% of the inmates were women. The infirmary was well equipped and included facilities for X-ray, physical therapy, inhalation therapy, a laboratory and pharmacy. Staffing was provided by six physicians, 37 nurses and 81 ward orderlies.

Although most of the Homes' patients showed senile changes, many were able to be kept on the ambulatory wards. If patients' confusion became extreme, however, they would be transferred to the infirmary unit. If the patient should fail to respond to treatment or become agitated, the delegation was told he would be transferred to a mental hospital for more intensive treatment. It was interesting to note that he would not be transferred to a Home for Psycho-chronics, and it was explained to the delegation that such a transfer could not be made on the basis of existing rules and regulations. Despite the fact that there were 1,300 beds in the Homes for Psycho-chronics, about one-third of the residents in the Home visited were former mental patients. These cases seemed largely to consist of cerebral arteriosclerosis and senile psychosis that were characteristic of the back wards of American state hospitals.

The delegation did not resolve the question as to how patients reached the Homes for Psycho-chronics. They were told that quiet schizophrenics, epileptics and discharged mental patients were all acceptable for admission at a general Home for Invalids. Indeed, it was pointed out that a patient's acceptance at the Home could be acknowledged prior to his leaving the mental hospital.

Tour of the Home

Facilities at the Home for Invalids were generally regarded as excellent. Rooms were attractive, with two beds to a room and a wall of glass that overlooked a central patio or the surrounding neighborhood. Bedside tables held

Medical staff members at the Moscow Home for Invalids.

personal possessions and mementos, and often a hot plate and tea pot. An inner door separated the sleeping area from a closet and bath room.

Centrally located day halls were bright and airy with easy chairs, tables, cabinets and television. There was also a cafeteria with tables for four. The kitchen was spotlessly clean, tiled in white and outfitted with excellent equipment. Kitchen workers wore white, unspotted garments.

Balconies at the Moscow Home for Invalids.

A patient's day room at the Moscow Home for Invalids.

The health unit at the Home had a laboratory, examining room, oxygen tanks and equipment for inhalation therapy. Workshops were equipped with foot-treadle sewing machines and work tables for making boxes, cartons and string shopping bags.

Throughout the tour the delegation was impressed with the attention paid to the emotional needs of these chronic patients. Husbands and wives were able to share rooms at the Home, and recent approval had been granted for a marriage between two patients aged 71 and 75. The delegation also noted an infirm wife being cared for by her husband.

The atmosphere here was one of dignity in attractive surroundings. Wards were clean and tidy and there was no odor; infirm and incontinent patients were carefully attended. Patients were neatly dressed—women in print dresses, sweaters, and babuskas, men in jackets, blouses, shirts and ties.

Facilities also included a library that contained American authors in translation, a theater and an assembly hall where an elderly woman was practicing on a piano for a concert to be given residents of an isolated collective farm.

In general, it was the delegation's impression that this facility offered quality care at a level above that available in convalescent-nursing care facilities in the United States. In the view of at least one member of the delegation, the facility was superior to one of the better known state operated geriatric facilities, with nursing care as good as, if not better than that available on geriatric wards in most American mental hospitals.

What was particularly impressive was the fact that the disabled and chronically ill, the retired person, and the former mental patient were assured dignified, humane care in an atmosphere at least equivalent to what could be found in the community.

Although the delegation did not get to visit a Home for Psycho-chronics, they were assured that the program in such homes was equivalent to the one being observed. Although there was likely to be more emphasis on farm work as a therapeutic activity, it was reported that all Homes for Invalids—Homes for Psycho-chronics included—had high-quality medical units and similar patient-staff ratios.

Institute of Psychiatry (Mental Hospital #4)

The Institute of Psychiatry is a highly prestigious facility serving the Russian Federated Republic. It is primarily concerned with clinical research and its application and its director, Dr. Fedotov, is one of the most distinguished psychiatrists in the Soviet Union.

The Institute is very well staffed with 136 research personnel, professors in the senior and junior grade, 18 non-research clinical psychiatrists, some 200 research associates from a variety of disciplines, including engineers, biologists, physiologists and chemists, and 50 Fellows training at either the ordinatura or aspirantura level. The delegation commented on the large number of psychiatrists at the Institute and they were told that of the roughly 10,000 psychiatrists in the Soviet Union, approximately 7,000 were concentrated in the Russian Republic.

Clinical departments included those for schizophrenia, geriatrics, exploratory therapy of psychoses, exogenous organic disorders, epilepsy, child psychiatry, narcology, social rehabilitation, psychopharmacology, biological bases of psychosis, sexual pathology as well as many laboratories.

The Department of Narcology in the mental hospital has 80 beds for therapy and planned treatment by an expert committee. Average stay ranges from 30–45 days and the person may be recalled every few months and followed for a period up to five years. It was reported that approximately 500 people were treated for alcoholism the past year and that 20% of all admissions to the hospital were for alcoholic difficulties. Some follow-up studies on discharged alcoholics were underway; preliminary data indicated that some 40% of the original population of alcoholics was not now drinking. Additionally, some 30–40% had not been drinking for three years.

The delegation was informed that the Institute maintained a special branch hospital of some 80 beds for alcoholics located 30 kms. outside Moscow. This is an intensive treatment facility with patients being selected by an expert medical committee. Patients remain in the hospital from four to six weeks with treatment consisting of antabuse equivalents, special diets, sleep therapy etc. After the initial period of treatment, patients are returned to the Institute for further examination.

The delegation had the opportunity to speak with the chief of the Department of Exogenous Psychosis. Although this unit supposedly dealt with external pressures upon the individual, it was reported that the patient population consisted primarily of toxic psychoses, those resulting from post-encephalitic conditions and other similar situations. It was admitted that some persons with reactive conditions were seen, but the impression was left that this was a very unimportant part of the unit's work.

The Institute has also established a Sexual Pathology Department. While there is little attention to Freud, there is an increasing awareness of the role of sexual difficulties in emotional disturbance. The major problems dealt with were frigidity, impotence, and marital incompatibility and it was admitted that the unit was swamped with clients. It was felt that sexual pathology, such as noted above, should be given greater attention in the medical schools. It was also reported that sexual deviations were infrequent in the USSR and were in the province of general psychiatry.

The study of epilepsy was one of the major areas of interest of the Institute. It was interesting to note that Dr. Fedotov claimed that the incidence of epilepsy in the Soviet Union was as widespread as schizophrenia, though its study had been more neglected. In Dr. Fedotov's definition, however, epilepsy covered a wide diagnostic spectrum including patients with mild psychomotor disturbances and even those with mood swings which were insisted to have an organic base. Emerging from the Institute's study of epilepsy was the finding that with proper treatment there was a more stable remission and greater ability to return to work. Currently being studied was the job performance of those successfully treated.

The psychopharmacology unit is divided into two departments—clinical and laboratory. There are 25 pharmacologists and 40 clinicians in the unit. It conducts a considerable amount of research on the evaluation of specific drugs as treatments for specific illnesses. The unit is also advisory to the Ministry of Health of the (RSFSR), with functions similar to those of the Food and Drug Administration in the United States. Before a drug can be licensed for use in the Soviet Union it must be cleared by a special pharmaceutical committee attached to the Ministry of Health. The committee requires complete data on animal and clinical trials.

The psychopharmacology unit also conducts an extensive training program. It gives a two-month indoctrination course in psychopharmacology for physicians throughout the Soviet Union. Recently, it was reported that a special course was given for 300 physicians from Siberia.

The delegation's visit to the Institute included a tour of Mental Hospital #4, which serves as a clinical facility for the Institute. The appearance of this hospital was little different from what the delegation had come to expect. There were the usual long corridors with the standard carpet runner, the dormitories of 8–10 beds, the dining room with tables for four, the day hall with piano, television and plants.

A unique feature of Mental Hospital #4, however, was the starvation treatment unit. In a special ward, patients go without water for 14 days and without food for up to 40 days. The patients are not confined to bed and at the time of the delegation's visit, several patients, including a number of women, were up and about the ward. The physician in charge of the ward explained the rationale of the treatment in terms of ridding the body of the bad "humors" which were incapacitating the patient. He indicated that he had been using this method for 19 years. It was the delegation's impression, however, that none of the patients gave any signs of starvation. It was suspected by the delegation that the staff of the hospital subverted the attempts at food deprivation, and indeed, this method of treatment was regarded as a "joke" in the hospital.

In any case, the physician reported that during the "resurrection period," as he termed it, those patients who lost 25 kilos of weight showed a 60% improvement rate. As far as the delegation could determine, the starvation regime was used nowhere else in the Soviet Union. And despite the questionable nature of the treatment, the fact that it existed indicated a considerable degree of tolerance for the medical maverick.

LENINGRAD

The V. M. Bekhterev Psychoneurological Research Institute

Founded in 1908 by the distinguished neurologist, psychiatrist and psychologist, V. M. Bekhterev, the Institute that bears his name is a major center for basic research in nervous and psychiatric diseases and in medical psychology. With an inpatient treatment capacity of 450 beds, its staff includes some 700 physicians and research personnel and of the total of 120 doctors, 105 are engaged in some form of research.

Its research laboratories include psychopharmacology, neurophysiology and medical electronics; metabolism and radioactive isotopes, biochemistry, pharmacology and medical psychology. Clinical research departments include experimental therapy of psychoses, rehabilitation therapy, geriatric psychiatry, vascular pathology of the brain, neuroses, alcoholism, epilepsy, brain surgery and a children's department.

Its annual operating budget of approximately 1.5 million rubles is very large by Russian standards (and quite large by American standards) and supports—in addition to research—training at the postgraduate level. Under the training program, hospitals may send their physicians to the Institute to work in the laboratories or do clinical research while their home hospital continues to pay their salaries for the two to three-month training period. Administered by the Ministry of Health of the Russian Federation, the Institute has close contact with the north and west oblasts of the Federation, which include Murmansk and Archangel, among others. Institute consultants visit these areas regularly to see patients or supervise research work. Lectures are presented to general physicians in the area, as well as clinical symposia for medical specialists. As is customary in many American research and teaching institutes, patients referred to the Institute are selected in relation to current research projects and the staff is able to select patients for study from oblasts outside the Leningrad area.

Surrounded by spacious grounds, including walks for patients, the Institute buildings included workshops, patient wards, clinical and research laboratories and one building for animal research. Many of the building exteriors are old, but inside they are uniformly clean, repaired and had standard furnishings. On the day of our delegation visit, scaffolding for repairs was in place in some areas and we noted that a telephone repairman was a woman.

Director of the Institute is Dr. Modest M. Kabanov, a young, dark-haired, quiet and forceful man of slight build.

Geriatric Section

The delegation had the opportunity to talk with Dr. Averbuch, Chief of the Geriatric Section of the Institute. He told us that investigations were in

Library at the Bekhterev Institute in Leningrad.

progress to explore differences between senile and vascular psychoses and pseudosenile conditions such as Alzheimer and Pick's diseases. In addition, there were studies of the effectiveness of anti-coagulant therapy; memory and repression in the elderly; and investigations in the relative efficacy of electroshock treatment, chemotherapy and other treatment modalities.

He indicated that his studies had demonstrated that EST is preferable to such drugs as Tofranil, even with geriatic populations, and that he was, in this regard, in essential agreement with Dr. Lothar Kalinowsky. Studies on delusions in old age and the impact of drugs such as ribonucleic acid on memory were not complete; early findings, however, seemed to indicate that methyl uracil could improve memory, even in seniles.

There was general agreement among the hospital staff that the number of geriatric cases requiring medical attention was increasing, and they were comparing results of treatment to ascertain whether seniles made better progress when segregated or when grouped with younger patients. The basic approach to the treatment of geriatric and senile populations was through conditioning techniques. Dr. Averbuch, for example, mentioned incontinence could be dealt with effectively by waking the patient the same time each night. Such measures, he commented, would eventually succeed.

The delegation observed a 26-bed ward for senile patients. Elderly women, some almost 90 years old, were being retaught simple tasks they had forgotten. They were practicing such exercises as turning on the water faucet, using a key to open the door and so on. Other women were relearning numbers and the alphabet through block building games.

Rehabilitation Department

This department, Dr. Kabanov told us, had been organized for only a year, with the aim of determining the efficacy of rehabilitation efforts in schizophrenia. Patients selected for the study have been schizophrenic for a period of from five to ten years. The principal attempt is to create a constructive therapeutic milieu based on a work-training program.

In the experimental program, patients are taught new occupations, in day hospital and night hospital care settings. Patients also receive training in the ryon NP dispensary or in special factory workshops. Social clubs had also recently been added to aid in the first steps toward social rehabilitation, which begins in the hospital while the patient is on inpatient status. The treatment regimen includes individual and group psychotherapy, therapeutic exercises, the use of chemotherapy and techniques of suggestion. Additionally, work is done with the patient's family with the aim of improving the patient's care and behavior after he leaves the hospital. Prior to the patient's discharge, drug use is limited and social goals emphasized.

It was Dr. Kabanov's impression that group therapy is a more effective tool in social rehabilitation than individual therapy; but he indicated that there was difficulty in training personnel in the attitudes and skills necessary in the social rehabilitation field.

Accompanying the social rehabilitation studies, there have been some biological studies focusing on the adrenal system and the effects of kesteroids, ACTH, and catecholamine metabolism. Other investigations include studies of individual differences; interpersonal relationships in the family before and during illness; sexual behavior; level of intellect; activity levels inside and outside the ward; and many others.

The delegation learned that Dr. Kabanov uses Dr. William Malamud's scale, in a slightly modified fashion, to measure performance, and the Wechsler Bellevue test. We were interested to note that there were ten psychologists in the Institute—one of whom was assigned to the rehabilitation department—more than we had seen in any other facility.

A section of a ward at Bekhterev.

Bekhterev Institute outpatient records.

Group Therapy

Group therapy as practiced in the Bekhterev Institute seemed quite similar to traditional group therapy practiced in the United States. In one group the delegation observed five patients, discussing their problems with a group leader and recorder. In another group, a psychiatrist was listening to a woman talk of her delusions. The therapist interrupted to ask the patient if she preferred individual or group therapy; her response was that she preferred group therapy because it helped her to be with others.

In still another group a psychiatrist was asking one of the patients to recite a poem. The patient, it was reported, had been an accomplished poet, but had been schizophrenic for the past ten years. Under great stress, with hands trembling, the patient recited her poem, after which she was assured by the physician that it had been a wonderful performance.

Neuroses Clinic

This unit consisted of 55 beds, 25 in the male section and 30 in the female. The delegation was told that neuroses were best treated on outpatient status; only severe cases required hospitalization. The typical inpatient population included persons with phobic and anxiety states who were unable to work. Average stays ranged from 1½ to 2 months with psychotherapy the main form of treatment. When the delegation asked whether the current emphasis on psychotherapy represented a change over the past five years, they were given a non-responsive answer to the effect that the Russians were "developing the principle of variations in the preoccupations with somatic complaints, including those of cardiac and gastric disability."

There was a non-hospital atmosphere on the ward with doors unlocked and patients encouraged to wear their own clothes. Patients stay at the hospital during the week and are sent home on weekends, armed with positive suggestions concerning their behavior. Patient government was quite important on the ward and work assignments and other regulations were developed by the patients themselves.

The dormitories consisted of eight to 12 beds arranged in the customary fashion. Corridors and halls were clean, attractively furnished and up to the standards the delegation had noted elsewhere.

In addition to assigning their own work details, patients are also encouraged to go outdoors. On the day we were visiting, a group was picking mushrooms in the woods. Several of them, the doctor told us, were cardiphobes with a fear of any kind of activity, but they were being taught to face these fears.

We witnessed one group therapy session similar in form to psychodrama. The five patients that day were imagining they had been transplanted to another planet and the therapist had asked them to tell of their lives on this planet. The session was being taped for further study.

Alcoholism Unit

The function of the alcoholism unit at Bekhterev was to study the pathogenesis, form and course of alcoholism. Dr. G. V. Fenevitsh, head of the unit, indicated his ideas paralleled those of Dr. Jellinek and that he had been in contact with workers in the field located in New York. He indicated he believed there was a somatic-biological basis for alcoholism, but that social and enviornmental factors were also of some importance. He felt that social factors might induce a person to drink, but that it was the biological substructure that produced the addiction.

He further commented that alcoholic psychosis is often a manifestation of polyaddiction of alcohol combined with the abuse of other substances such as barbiturates, codeine, etc. He also felt there was a marked relationship between alcoholism and other psychiatric disorders, notably schizophrenia.

Although the treatment of the alcoholic patient usually begins with the narcologist at the NP dispensary, selected patients may be sent to the Institute for study. The principal task of the Institute is detoxification followed by conditioned reflex treatment, after which the patient is returned to the dispensary for continued management. Dr. Fenevitsh indicated that the results of treatment of alcoholics were no better at Bekhterev than at other clinics and that real progress would not be made until the pathogenesis of alcoholism was better understood.

Workshops

The delegation had the opportunity to visit some of the workshops scattered throughout the Institute. At the time of the visit there were some 320

A dining room at Bekhterev.

patients—most of them out-patients—working in the various shops. In one shop visited patients were bending metal tubing for folding cots and stool frames. In a second shop patients were making rope, beginning the process with bags of jute and spinning them in a very long, large room. In a third shop, others were working at power sewing machines making bed sheets, hospital gowns and other items used by the hospital patients.

Patient-workers included schizophrenics, epileptics and mental retardates. As in other workshops, most patients live at home and work a six-hour day. In addition to their medication, they receive two meals a day, a piece-work salary and may additionally receive a full or partial pension from the government.

It was reported that the work in the shops was scaled in difficulty. As the patient's skills increased he was advanced from workshop to workshop. At two of the shops, for example, poorly adjusted patients were turning out string shopping bags and other simple products. In the more advanced shops, however, better adjusted patients were producing optical and electronic equipment and building ECT machines. It was reported that, in one of the shops, all of the medical equipment in use at the Bekhterev was produced.

Generally speaking, the eight workshops at the Institute were reported to be quite successful. They grossed in the neighborhood of one million rubles a year, of which some 200,000 rubles was profit, and the funds were used to pay for recreational activities and to finance new hospital construction.

The delegation had a number of questions concerning the use of patients as workers. Typical are the following:

Q: "Do you take as patient workers those who can be expected to produce a profit in the workshop?"

A: "The medical committee picks the patient; the workshop never knows the work capacity of the patient selected. Therefore, the answer to your question is no. The orientation is medical, not vocational."

Q: "What happens to patients who do not produce?"

A: "We try them on the most primitive task they can accomplish and if there is no progress after a reasonable time, we drop them."

Q: "Who selects the projects?"

A: "The three deputy directors discuss suitable work enterprises and select from among alternates. Some of the things selected turn out to be unprofitable."

Q: "Is there a subsidy from the government?"

A: "No."

Q: "Would a poor worker be dropped sooner than a good worker?"

A: "There is really no difference in the length of stay in the workshop; if anything, it would favor the poor worker who stays longer until he learns the required proficiency. Some may stay as long as two or three years. It's a medical decision and the intent is to return the worker to full community employment if this is possible. The patient who shows a relapse and whose symptoms return may have to continue in the workshop but then his psychotherapeutic sessions would also continue. Out of 15 patients recently returned to industry, 5 came back to the workshop. There is no waiting list."

Day Center

The Bekhterev was one of the relatively few psychiatric installations in the country to have a day hospital. It provided space for 25 patients and was open between the hours of 9 : 00 a.m. and 5 : 00 p.m. There were a number of rooms for resting purposes, a hall with ping-pong tables, television, phonograph and chairs and sofas. Most of the patients in the day unit were recruited from the rehabilitation section of the Institute, though some were referred from the hospital and outpatient services of the Institute. In addition to the recreational activities available, it was reported that the patients could, if they chose, participate in the workshop activities. The day center was staffed by a physician, a nurse with "social training," two instructors, what was termed an "ego therapy" instructor and two orderlies. One of the workshops in the day hospital was as fine as any we had seen in the country.

In a pattern familiar in the United States, it would be untrue to state that there were few day hospitals. Every NP Dispensary has a day hospital and there were many examples in the country. The equating of sheltered shops and the presence of patients all day long in a work situation where they were fed a meal under medical supervision constituted most day hospital programs. However, the familiar pattern seen at the Bekhterev Institute with a varied program including group therapy, recreation, nursing care, and so on, gave this one a different orientation from the others.

Emergency First Aid Substation #1

This facility is one of the 14 health emergency substations serving Leningrad, a city of some 3.6 million people. It is located in a brick building, very much like a police or fire station in the United States.

Facilities include the director's office, a room where the emergency teams await calls, a dispatcher's desk, work rooms for assembling emergency kits, and storage racks for medical equipment.

The delegation was favorably impressed with the excellence of the equipment available for emergency use. There were specialized pre-prepared kits for use in resuscitation, auto-trauma, cardiac collapse, poisoning, burns, shock and so on.

Substation #1 has 28 physicians on its staff. These physicians, under a faculty established last year, must be specially trained to provide emergency care. Ordinarily three years of experience is necessary to qualify for the program. In addition to the physician, emergency teams consist of two nurses or feldshers, and an ambulance driver. There are seven such "brigades" at the substation, with at least four brigades available at any one time. Additionally there are 14 ambulances with four always in a state of "ready alert."

Substation #1 receives an average of 75 calls per day. The four most common types of emergencies are reported to be trauma, shock and resuscitation; cardiovascular; central nervous system; and psychiatric. For psychiatric emergencies, there is a specialized substation, #13, with a staff of psychiatrists. The delegation, however, did not get to visit this latter facility.

Neuropsychiatric Dispensary, Moscow Ryon

The organization of health care in Leningrad was similar to that observed by the delegation in Moscow, with the same framework of polyclinics, dispensaries, mental hospitals and other specialized facilities.

The particular dispensary visited was related to Mental Hospital #4, a somewhat unusual facility in the sense that admissions were accepted from throughout the Soviet Union. The special emphasis of the hospital was in the provision of immediate care in states of acute illness. With remission of acute symptoms, however, patients were returned to their home communities for follow up care and extended treatments.

All told, there were ten mental hospitals serving Leningrad proper, ranging in size from 200 to 1,500 beds. The total of 7,500 beds averages out to a ratio of 2.2 beds per thousand population. In the outlying areas surrounding Leningrad there are an additional eight mental hospitals with a bed ratio of 1.5 per thousand population.

In addition to Mental Hospital #4, resources available to the neuropsychiatric dispensary include the children's mental hospital, the Pavlov Clinic for Neuroses and a specialized alcoholism unit. Under the auspices of the City Health Department there is also a psychotherapeutic center which serves as a consultation resource and training center, a logopedia for training of speech specialists, a drug addiction center and an occupational therapy unit. These city administered units are charged with the responsibility of collecting information, coordinating services, and providing instruction and continuing education.

The dispensary itself was somewhat unusual in the sense that it was regarded as an experimental facility. As such it had even more than the usual complement of professional staff. There were 22 psychiatrists (as compared to the 13–16 psychiatrists usually found in dispensaries), 42 nurses and 36 ward auxiliaries. It is a fairly active unit and in 1966, it recorded 80,000 patient visits.

Because of its status as an experimental facility, the dispensary is closely affiliated with the highly prestigious Bekhterev Institute. The Professor of Psycho-pharmacology at Bekhterev serves as a consultant to the dispensary, and dispensary patients are used in the testing of new drug treatments. Other personnel from Bekhterev use the dispensary as a training center and provide refresher courses to psychiatrists and local physicians.

Also, in conjunction with the Bekhterev Institute, the dispensary was attempting to develop "enriched" psychiatric services in several of the uchastoks. The goal was to provide an unusually high doctor-patient ratio with the aim of returning the patient to his home community as quickly as possible. While the costs of the program were reported to be nearly five times that of regular services, the overall cost per patient had been cut in half. Prior to the institution of the program, the average hospital stay of mental patients in the Leningrad area had been six months. Since the program's inception, however, combined with efforts at early detection, average hospital stay had been reduced to 90 days. It was pointed out that despite this reduction there had been no reductions in mental hospital populations; since beds could be turned over more readily, more patients could be served.

Tour of the Dispensary

Despite the dispensary's being an "unusual" facility, it was essentially similar to other dispensaries visited by the delegation. The office of the director, Dr. Bresloff, was attractively furnished with drapes, carpets and padded doors. Throughout the dispensary there were plants, pictures and flowers, as well as the familiar striped rugs on the parquet floors.

The delegation noted the typically furnished offices for physicians, the laboratories, a logopedia, an alcoholism unit, the experimental drug therapy unit, and the children's department.

On the third floor of the dispensary the delegation found a day-night hospital—one of the few in the Soviet Union. During the day approximately 100 patients were in attendance, with 20 patients staying the night. This latter group consisted of patients with severe neuroses, but who were nonetheless able to work during the day. Although there had been considerable demand to expand the night unit, it was explained that the facility was currently limited to twenty-four beds.

The occupational therapy units appeared to be typical ones with the familiar posters, photographs of patient outings and posted schedule of activities. Patients were engaged in sewing activities, making gloves and bags, and assembling plastic parts. Other patients were reading, knitting or playing chess. Rooms in the children's unit were quite attractively furnished with child size accessories, play material and in some cases, aquariums. The alcoholism unit had facilities for group therapy and the delegation noted a hydrotherapy room with three tubs and a Scotch douche.

The general impression of the delegation was that this facility in itself was an "enriched" installation. While it provided the range of treatments and services typical of the neuropsychiatric dispensary, its high-staff ratios, and quality consultants helped raise the level of the program to one where experiment, and perhaps, innovation were acceptable and, indeed, expected.

THE UKRAINE

Kalinovka Central Ryon Hospital

The Kalinovka Central Ryon Hospital covers the northern part of the Vinnitsa Oblast, serving a population of some 90,000 persons. The area is largely agricultural with wheat, sugar beets, honey and fruit being the major products. Dairy farming, poultry raising and fishing are also popular and what industries there are relate to the processing of the agricultural products.

The Central Ryon covers a larger area than most ryons with a total of 645 general hospital beds; the Kalinovka Central Ryon hospital has 250 of these. There are also 43 feldsher midwife centers in the ryon and three industrial health units. All told, there were approximately 9.5 beds per 1,000 persons, and 137 physicians, or 15.5 per 10,000 population.

The hospital is organized to provide inpatient care for surgery, internal medicine, children's disorders, EENT, communicable disorders, maternity and GYN. Additionally, there are outpatient services in several specialities, an emergency unit, a clinical and pathological laboratory, and a sanitary department with appropriate facilities.

Surgical Ward

The delegation toured a few of the hospital wards. The surgical ward was plain and practical, with no evidence of frills or luxury. There were, for example, no floor grids with grounding for static electricity in the operating room, no piped oxygen, no call system, no adjustable beds or overbed tables, no chart racks, no medical carts and even no wheel chairs in evidence.

There was however, a modern gas anaesthesia machine, a hand resuscitator and a cardiac stimulator. Although there was a bactericidal lamp in the ceiling, there was no hesitation in allowing the delegation to walk through the sterile operating room.

A four-bed dormitory room with two beds served as a recovery room. It was equipped with the necessary supplies and the delegation noted an extra oxygen tank outside the door.

Pediatric Ward

The delegation also toured the pediatric ward. It was a pleasant ward with many children in small private or semi-private rooms. The largest dormitory consisted of eight beds. The delegation saw one dormitory for young adolescent girls with rheumatic fever. As in all the dormitories, a nurse was present.

In addition to the facilities for children, the delegation also noted a small dormitory for mothers, enabling them to stay with their sick children. The Russian concern for children seemed no idle boast; it was well reflected in the arrangements for their medical care.

Psychiatric Facilities at Central Ryon Hospital

The Central Ryon Hospital is one of the few Russian general hospitals to have a psychiatric ward. It was developed in 1960, and it consists of 15 beds located on an internal medicine ward of some 40 beds. The relatively small number of psychiatric beds was commented on by the director of the unit who pointed out that only psychiatric patients who were easily managed and could be discharged within thirty days would be admitted to the ward. All others—those in need of more intensive treatment or patients who became agitated or excited on the ward—would be transferred to the Oblast Mental Hospital in Vinnitsa.

There was little differentiation between psychiatric patients and medical patients regarding their participation in hospital activities. The delegation

The courtyard at Kalinovka General Hospital.

observed the psychiatric patients in the occupational therapy shops and engaging in a variety of recreational activities.

In addition to the ward in the hospital, psychiatric facilities at the Central Ryon Hospital include an affiliated neuropsychiatric dispensary, staffed by three psychiatrists, a neuropathologist and four nurses. Treatments at the dispensary included the typical range of psychotherapy, physical therapy, chemotherapy and workshop therapy. As part of the rehabilitation program, patients were also placed on the surrounding farms, under the care of the local uchastok physicians. It was reported to the delegation that these physicians were specially trained to work with psychiatric populations under the general supervision of the dispensary psychiatrist.

The dispensary itself was one of five buildings scattered on the campus. Adjacent to it were buildings of the sanitary division, and under construction was a new surgical pavilion. The main hospital rounded out the complex and all buildings were connected with garden walks interspersed with colorful benches.

A visit to the dispensary revealed the typical arrangement of offices for psychiatrists and dentists, laboratories, therapy rooms and so on. As expected there was a separate children's section.

Although the delegation was less than impressed with the psychiatric ward in the hospital, in general terms they found the hospital to be an essentially adequate facility. Overshadowing the lack of "luxury features" was the close coordination of the hospital with the other medical resources of the oblast and, once again, the insistance on implementing a continuity of care framework.

Oblast Mental Hospital, Vinnitsa

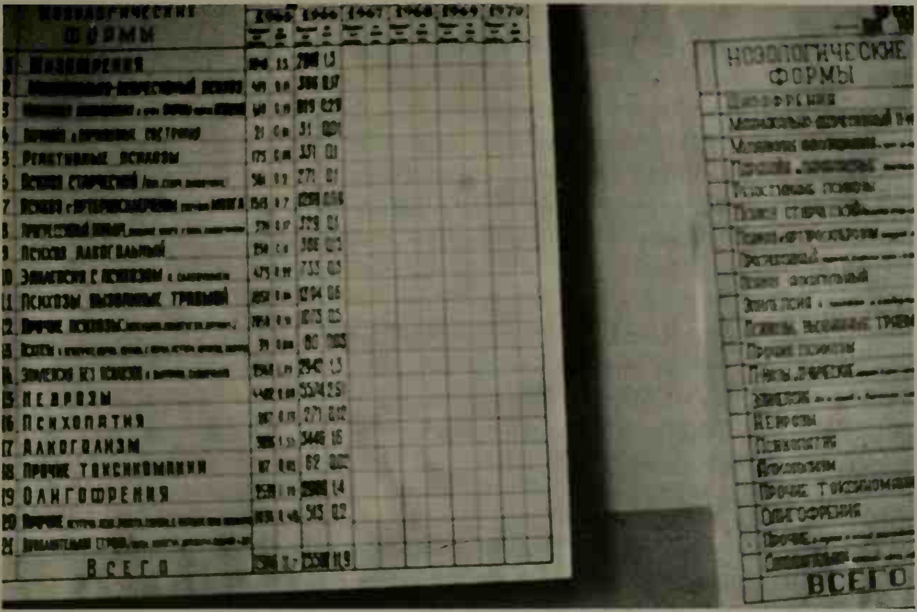
The mental hospital serving the Vinnitsa Oblast is one of the oldest such hospitals in the Soviet Union. Destroyed during the Russian Civil War and again by the Nazis in World War II—when all the patients were murdered—the present facility is a completely rebuilt installation.

The hospital serves a broad area that covers part of the Carpathian mountains, steppes and forestland. It is largely a rural area, with only 170,000 of its two million people living within the city limits of Vinnitsa. Despite the distances and as a reflection of the organization of health care within the Oblast, polyclinics were located so that one need never travel more than 10 kilometers to reach one, even though the most remote polyclinic was more than 160 kilometers from Vinnitsa proper.

Since the Vinnitsa Oblast covers a large, rural area there is a special emphasis on ensuring that medical services will be available to the outlying ryons. In contrast to most of the urban dispensaries, all of the rural dispensaries in the Vinnitsa Oblast have in-patient facilities so that patients can be readily transferred from the hospital to their home communities. Additionally, nurses regularly visit patients in the country and psychiatrists consult with the local uchastok physicians.

The hospital itself was located on more than 120 hectares of land, with buildings spread out in a campus type arrangement. Spaces between the buildings were planted with flowers or filled with trees. The delegation noted large open gardens in which men and women were working, and one of the fields was filled with cabbages.

Dr. Roman Marianchic, Director, Vinnitsa Oblast Mental Hospital, at the "Hitler Bunker," used by the Nazis in World War II.


НОЗОЛОГИЧЕСКИЕ ФОРМЫ
НЕВРОЗЫ
ПСИХОПАТИЯ
АЛКОГОЛИЗМ
ПРОЧИЕ ТОКСИКОМАНИИ
ОЛИГОФРЕНИЯ
ВСЕГО

Wall chart at Vinnitsa, showing mental health statistics.

The Vinnitsa hospital is somewhat unusual for a rural hospital by virtue of its size and scope of its program. It has 1,900 patients, 23 departments and a staff of 117 physicians (83 psychiatrists), 447 paramedical personnel and 722 orderlies, ward maids, and auxiliaries. As with most Russian mental hospitals, there is a high bed usage ratio, and in 1966, the hospital recorded 5,263 admissions.

There is also a close relationship with the Vinnitsa Medical School, and the hospital is a training center with both Chairs of Psychiatry and Neurology.

Attached to the hospital is a neuropsychiatric dispensary which is responsible for the provision of a broad range of outpatient and consultative services, both for children, and in separate departments, adults.

There is also an active research program in the hospital with specialized laboratories for investigations in experimental psychology, clinical psychiatry, electroencephalography, neurology, etc. There is particular interest in the study of techniques used in occupational therapy and the value of work rehabilitation, and the hospital maintains fourteen workshops for such therapy. The interest in rehabilitation dates back many years and the delegation was shown a book on the subject, based on hospital experiences, dated 1902.

Although the Vinnitsa Hospital serves as the focal point for the delivery of psychiatric services in the Oblast, it was commented to the delegation that the development of a high quality program was a long and arduous procedure. The chief medical officer of the Oblast—an internist—spoke of the considerable resistance to psychiatry on the part of the general practitioners in the area and of the years of effort needed to change the negative attitudes.

The first building visited by the delegation was Psychiatric Clinic #21. This ward, housing 80 women, is a training facility for the affiliated Vinnitsa Medical School. Major treatments available included insulin—both coma and sub-coma forms—electroshock, tranquilizers and anti-depressant drugs and intermittent sleep therapy. There were also combinations of these treatments and a limited amount of psychotherapy.

Ordinarily small groups of ten or so students come to the hospital for two weeks of intensive study. For their elective work, somewhat larger groups of twenty to thirty students receive a period of instruction of two months duration.

The Head of the Chair of Psychiatry—an elderly, erudite gentleman—was deeply interested in the training program. He commented that the 40 students under his supervision were getting a great deal of bedside training, and there was additionally much training of the general practitioner in techniques of psychiatry.

Tour of the Wards

Most of the wards at the hospital were U-shaped and pleasantly furnished with carpets, ornamental room dividers, plants, flowers and pictures. Dormitories contained seven or eight beds, each with colorful bedspreads. The Director of the hospital, Dr. Roman Y. Marianchik, indicated that even this was too large. When he had become Director of the hospital, he explained there were as many as eighty to ninety patients in a dormitory. These were broken up to the smaller units observed by the delegation, but the goal was to have a maximum of four beds to a ward. There were currently 320 wards in the hospital; there was no reason why there could not be 600 wards.

On the wards many of the patients wore their own clothes and those with open-ward privileges were allowed to travel to Vinnitsa. All patients worked in occupational therapy, either on the ward or in the hospital workshop. In the ward occupational therapy class there were twelve patients working at drawings, making puzzles, using the sewing machines or making artificial flowers. Nurses were everywhere.

Between the wards there were visiting rooms for relatives. These rooms also were pleasantly furnished with carpets, tables, chairs and sofas, some of which were covered with red velvet. Additionally, there were the usual plants, flowers and pictures.

The treatment room was less well equipped with drugs than a similar room in the United States might be. There were, however, adequately equipped examining rooms and physician's offices. Patients with minor physical illnesses were kept in bed and treated on the ward. When more definitive care was needed, the patient was transferred to the general hospital, as there was no infirmary ward or medical service located at the hospital itself.

The Workshops

The entrance to the hospital workshop is decorated with an exhibition of materials made by the patients—the delegation noted reed and rattan work, clothing, chairs, draperies and pottery. In the shops the delegation observed patients making boxes, cutting paper, and making plaster models for architectural designs used in public buildings. Some patients were making artificial flowers and attractive arrays of artificial leaves. Other women were making hospital sheets and pillow cases and a number were working diligently on power-sewing machines. In another section, a former patient was supervising the construction of laundry and farm baskets from freshly-stripped willow. This construction was more than a therapeutic exercise; they were the same baskets the delegation had observed in use on the collective farms. In addition, there were facilities for the construction of mattresses, chair-repair, and a shop where straw matting was woven into covers for the piles of sugar beets grown on the collective farms. In all of these shops it was customary for patients who were not yet ready to work to be allowed to stand around and watch the others until they themselves felt like participating.

In addition to the actual workshops, building maintenance was performed by the patients and the delegation was told that the workshop building in which they were visiting had been constructed by patients.

During the delegation's visit to the workshop, a patient became acutely agitated and had to be returned to the ward. The delegation watched the consideration and patience expressed by the nurse toward the patient, and the removal was accomplished without evidence of excitement or overly controlling behavior.

The Neuropsychiatric Dispensary of the Vinnitsa Mental Hospital

The approach to the dispensary was through a tree-lined avenue with flower beds on either side. Inside, the lobby had a waiting room with a coat-check room, a pharmacy, posted bus schedules and a group of tables and chairs. There were two psychiatrists on duty at the dispensary and the

Patients making paper flowers at Vinnitsa Mental Hospital.

Administration Building, Mental Hospital at Vinnitsa in the Ukraine.

delegation was told that two other psychiatrists were making home visits. In addition to the four psychiatrists assigned to Vinnitsa, the dispensary had a staff of 11 other psychiatrists who were consultants to various agencies through the Oblast. Each physician saw from 13 to 15 patients a day, usually for a half-hour session. There were facilities for psychotherapy with small groups, and a child psychiatrist and narcologist were available as consultants.

The delegation visited the record room of the dispensary which is open 24 hours a day. Records were categorized by a color code which indicated ryon location. Whenever a patient was transferred to another medical facility, his records would follow him, with the appropriate notations. There was evidence of an effort to compile statistics on the incidence and prevalence of mental disorder in the various ryons, and there was a statistical section in the building for just this purpose. It was reported to the delegation that the admission rate for the oblast was about 12 patients per thousand population. While the incidence of schizophrenia had remained stable over the past years, it appeared that the incidence of senile psychosis was rising sharply.

On the second floor of the dispensary there were more offices. The delegation observed four patients in group therapy that was described as rational-supportive in character. In another office a logoped was teaching a boy, accompanied by his mother, to pronounce words and identify objects. A stomatologist's office was well stocked with two dental chairs and associated equipment. In addition, the delegation noted various laboratories, a number of offices for child psychiatrists, and rooms for a narcologist and an opthalmologist.

The most significant features, however, were the scope of the program, and the close relationship between the hospital and the other health services in the Oblast. The fact that the Vinnitsa hospital was a rural-based facility made this coordination all the more impressive.

Notes on Children's Facilities Visited

MOSCOW

Children's Polyclinic #22

This polyclinic is located on the first floor of a Moscow apartment house. It is a typical children's polyclinic and it encompasses a district of 12 uchastoks and serves a population of 10,000 children ranging in age from infancy to 16.

Child care begins with the mother's pregnancy, and polyclinic #22 is the focal point for physician's home visits, and later, baby care. The delegation noted the standard equipment for weighing and measuring infants, and the walls were covered with charts depicting normal growth and development patterns.

The polyclinic has facilities for ENT, psychiatry, neurology, physical therapy, medical gymnastics and oxygen therapy. In keeping with the preventive orientation of Russian medicine, there were graphs depicting the decline in incidence of various disease entities. One chart that caught the delegation's eye indicated that the incidence of rheumatic fever in the district had dropped from 41 cases per thousand in 1960 to 20 cases per thousand in 1966.

In addition to the treatment functions of the polyclinic, there is close collaboration with the schools of the district. Polyclinic #22, for example, provides the physical examinations for all children on their entrance to kindergarten at age three, and again at seven on their entrance to primary school. In addition, polyclinic #22 provides consultation to the seven regular schools, 1 boarding school, and 22 kindergartens of the district.

The delegation spent a good portion of their visit speaking with the psychiatrist "on detail" from the children's neuropsychiatric dispensary. She described her functions as falling within the bounds of treatment, prophylaxis and continuous education. She reported she was currently "following" a group of children, largely schizophrenic but also epileptic, neurotic, mentally retarded and brain damaged.

Of the 10,000 children served by the polyclinic, 190 were currently in psychiatric treatment. Approximately five children were seen each hour, with an average session lasting twelve minutes.

The psychiatrist stated a good deal of her work consisted of screening polyclinic patients for psychiatric disturbance and she reportedly spent additional time in consultation with school personnel and other polyclinic physicians. She further indicated she had been studying 50 children who had been born with brain damage.

She described her treatment regime as including vitamin therapy, massage, curative gymnastics and often, one of the new drugs. For the treatment of mental retardation she was currently using glutamic acid and vitamin B12. She indicated all treatments were available at the polyclinic—except hypnosis—and that when a child needed treatment beyond her capacity, he was referred to the NP dispensary. Although she stated that psychotherapy was the treatment of choice for all children, it was clear that her emphases were organic and that psychotherapy—at least as understood by the delegation—was not, in practice, a high priority treatment.

In relation to the 3,000 clinic visits a year, the psychiatrist had an active case load of 190 children. Most of these were referred by the other medical specialties at the clinic, or through the school system.

The delegation made a cursory inspection of other facilities at the polyclinic. The physical therapy department seemed to be a typical unit, with all the usual equipment.

The vaguely titled "medical gymnastic" section turned out to be a unit particularly concerned with post-traumatic situations, scoliosis and development following heart surgery.

The other units—dental, surgery, opthalmology, etc., seemed typical clinic-medical facilities and generally were adequately equipped and instrumented.

Children's Sanitarium, Ryon #35

This children's sanitarium was established in 1962. Its director, Dr. Bardenstein works half-time in this facility and half-time supervising the ten children's clinics scattered throughout the ryon.

Children's sanitarium, Moscow.

At the time of the delegation's visit there were 22 girls and 13 boys in residence. Diagnostically, they were classified as neurotic or mildly retarded and all were reported to be having difficulties in school. The staff consisted of three physicians, eight nurses, six teachers, one speech therapist (logoped), seven ward maids, and additional personnel.

The sanitarium cares for approximately 140–150 children a year, with three months being the modal length of stay. Although some children may stay as long as six months, if further residential care is still needed the child will be referred to one of the Forest schools.

The child's home environment is an important consideration in determining the likelihood of admission to the sanitaria. A "typical" background might be illustrated by the family with an alcoholic father who, refusing treatment, foments a particularly stressful atmosphere at home. Placement of the child might be recommended so as to remove him from the unhealthy situation at home. Under such circumstances, however, the parent's consent is necessary.

With regard to treatment, the sanitarium was equipped to provide electronarcosis, speech therapy, neuroleptic drugs and hydrotherapy. In addition, there were two classrooms, two dormitories, a kitchen and individual storage areas for each child. The delegation observed that there was very little play area surrounding the sanitarium and there was no equipment for recreational purposes.

Dr. Y. Bardenstein, doctor-in-charge at a children's sanitarium in Moscow.

A child's typical schedule follows:

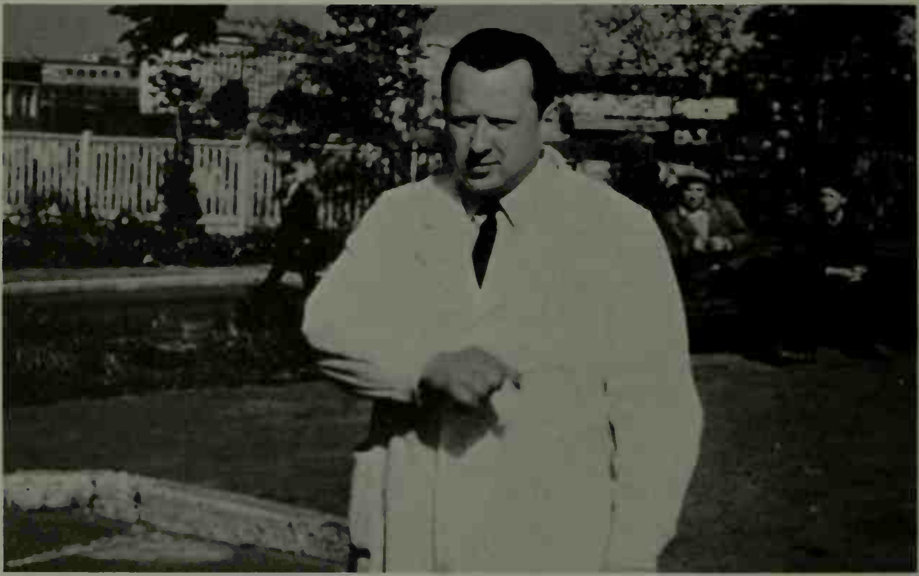
Children are awakened at 8:00 a.m. with breakfast scheduled at 8:30. After breakfast there is some free time either spent out of doors playing, or working in the garden. From 10:00 a.m. to 1:00 p.m., there are three school periods of 40 minutes each, followed by a light lunch and another play or garden work period. At 4 o'clock there is a bed rest, at five o'clock, a light snack with fruit followed by another period of recreation and play. Prior to supper at 7:00 p.m., there is a homework period of from one-half hour to one hour. Supper is followed by free time during which the children read, play, watch television, or do additional homework. A shower or bath ends the day with bedtime at 9:00 p.m.

Kindergarten for the Mentally Retarded

This kindergarten is located in one of the newer buildings in Moscow. Despite this, however, the building was very poorly constructed and it looked considerably older than its age. The delegation noted that stairs were chipped and cracked and carpets were loose. An effort, however, had been made to beautify the area around the building and there were numerous flower plantings.

There are 200 children in the kindergarten, divided into nine groups based on their intellectual ability. The Russians did not use a standardized intelligence test and they depended upon a clinical diagnosis by the physician and an educational assessment by one of the teachers.

The stated purpose of this facility is to raise the educational level of the children so that they may enter the regular public schools at age seven. This requires a major effort and it is reflected in the kindergarten's large staff.



The Director of Children's Neuropsychiatric Dispensary #1, Moscow, Dr. K. N. Nazarov.

Students in a corrective class in Moscow.

The staff of 147 included 3 psychiatrists, 19 teachers, 23 nurses, physical and recreational therapists and a variety of other ancillary personnel.

At the time the delegation toured the kindergarten, the children were having lunch in several bright and cheerful dining rooms split up into tables for four. Following lunch, they laid their clothing neatly out on chairs next to their beds and retired for an afternoon nap.

In speaking with the officials there was the admission that a fair percentage of the children would not achieve the goal of entering the regular elementary school. These children would be sent to a special school for the mentally retarded operated by the Ministry of Education. If further formal education—even at this level—was not feasible, they would be sent to a Home for Invalids. The important point noted by the delegation, however, was that the Russians were devoting considerable financial and manpower resources to the care of children whose potential contribution to the Russian economy was, at best, limited.

In much of the literature read by the delegation prior to visiting Russia, there had been constant references to the Soviet emphasis on good health care as a means of creating a productive citizen. In actual fact, very few of the mentally retarded children in this kindergarten would ever become productive citizens. When the director of the kindergarten was asked about his philosophy with regard to these children, he replied very simply: "We think that every child, however limited, is entitled to the best that we can give him. Even if he cannot be absorbed into any educational process, we must make his life not only endurable, but somewhat joyful."

Children's Dispensary #1

The Children's Neuropsychiatric Dispensary #1 is a comprehensive facility for the practice of child psychiatry. It is the only such dispensary in Moscow and, with its 13 departments, it serves as a focal point for consultation, inpatient and outpatient care and the training of child psychiatrists.

The consulting service covers all of Moscow. While the 26 physicians in this service are officially part of the dispensary staff, they often work in the various children's health services located throughout the city.

The dispensary is able to care for approximately 530 children, grouped by age and condition, with 40–50 children in each of the 12 inpatient departments. For this population there was a staff of 83 physicians, of which 63 were child psychiatrists, 280 nurses, 32 speech therapists, 238 ward assistants, and 60 teachers. Including the housekeeping and maintenance personnel, there were more than 800 people.

Children's Dispensary #1 is located on the grounds of the Children's Hospital and the delegation was very much impressed with the physical setting. The 45 acres included a zoo, carefully tended gardens, several small parks and orchards. There were no "keep off the grass" signs, and indeed, the chil-

An ambulance arrives at the Children's NP Dispensary #1 in Moscow.

Beds in a ward at the Children's NP Dispensary.

dren were largely responsible for the care of the zoo animals and they helped in the planting and harvesting of the orchards' cherries and apples.

The delegation's tour began in the administrative office of the chief psychiatrist. We were shown the library, conference room and the clinical laboratories, the latter particularly well equipped with 8 and 16-channel EEG's and the latest Japanese electronic analyzers.

The delegation observed three speech classes where children were doing breathing exercises and speaking in front of mirrors. There were reported to be 40 inpatients in the speech therapy section, and although the delegation was somewhat surprised by this fact, we were told that the children needed concentrated training and that parents were not at all disturbed by the period of hospitalization. As elsewhere in the Soviet Union, there is a very strong emphasis on the correction of speech and communication disorders.

The delegation also observed some classrooms for psychotic and neurologically damaged children. At the time of the visit, there were 45 children in residence with a teacher for every ten children. It was said that when a child was too disturbed to attend day classes he was given tranquilizers and sent to evening classes. The emphasis of the classes was strongly academic. The teachers emphasized that in most cases the children could keep up with the educational level of comparable grades in schools in the outside community. They stressed that the children were expected to do well in school—even if it meant doing a considerable amount of homework in the evening before bedtime.

The average length of stay in this unit was reported to be from two to three months. On discharge, the child would continue to be seen by the psychiatrist located at the children's polyclinic. If further residential treatment was necessary, he would be transferred to a facility specializing in longer term residential care.

In the unit for pre-school children, boys and girls were grouped together. Most of the 40 children were reported to be epileptic, schizophrenic or cases of behavior disorder. Although the average length of stay in this unit was two months, it was understood that the children could stay up to two years. The goal was to bring these pre-schoolers to a level where they could attend

Physical therapy is also provided children at the NP dispensary.

the regular kindergarten, with supervision by the polyclinic psychiatrist. While there was reluctance to discuss the avenues available if treatment was not successful, the children, presumably, would be sent to one of the Homes for Invalids.

The delegation was told that there was frequent consultation with the parents regarding these children. In one of the offices, a nurse was talking to the mother of a four-year-old boy who was mildly retarded, but quite agitated in his behavior. The boy's physician indicated that the child was gaining in his understanding of language and he asked him to recite a poem, which the boy did much to his mother's satisfaction.

The major treatments in use at the dispensary were the tranquilizing drugs. In cases of depression, anti-depressants and shock were used. In the case of psychotic boys, insulin treatment was used (full coma). Although not mentioned, a major treatment modality seemed to be the warm concern supplied by the medical personnel to these children. On one of the wards, for example, an autistic child was sitting on his bed not participating in the school activities. He was being comforted by a nurse who was engaging his attention with a series of paintings which she was showing him. However, psychotherapy, in the formal sense was not much used.

The delegation was very much impressed with the high quality of program visible in even the most disturbed ward. Of particular note were the vases, plants and draperies in abundance, reflecting the expectation that children would respect property and control their behavior. There was a high staff ratio, small groups of patients, and excellent leadership.

In general terms, the delegation found the dispensary to be a high quality facility. While there was not the opportunity to study in depth the various services offered, there was little question that the staff was devoted and competent, and the atmosphere, one of hopefulness and optimism.

Public School #739

Public School #739 is one of the 800 schools serving Moscow. It is a "middle school," distinguishing it from the "lower school" nurseries and kindergartens and the "upper school" universities and technical schools. At the time of the delegation's visit, there were 875 children between the ages of 7 and 17 enrolled in its ten grades.

Public School #739 had a medical unit with a full time physician and nurse on duty. The principal function of the unit is to provide early treatment in illness or injury and to promote the practice of preventive medicine. As part of this latter framework, there are regularly scheduled physical examinations for each child, once a year. This includes dental, eye, ear, nose and throat examinations, fluoroscopy, and an orthopedic examination. When required, specialists from the local polyclinic may participate in the examination and if special study is indicated, referral will be made to the polyclinic or children's hospital.

Despite the extensiveness of the physical examinations, it was the delegation's impression that screening for psychiatric disorder was perfunctory. If there is an emotional or mental disorder, it *may* be detected during the initial polyclinic examination before entry to school. Most cases of emotional disturbance, however, are detected by the teacher during the school year, with referral to the consulting psychiatrist from the polyclinic.

Despite the close relationship between the schools and polyclinics, the delegation had the impression that the psychiatric consultant visited Public School #739 only twice a year. At that time she saw all the children who had been referred to her by the teachers. Of the over 800 children at the school, 19 had been identified as in need of psychiatric treatment and all were being seen at the polyclinic. An additional 30 children were not being treated but, according to the psychiatric consultant, were under observation.

It was reported that most children who exhibited disturbed behavior could be handled by the school. Those who proved beyond the school's capacity were referred to the neuropsychiatric dispensary, with additional referral to the sanitaria, the mental hospital, and the Forest Schools available, if necessary. Strict discipline was used to cope with the delinquent child and if medical resources did not prove effective, the delegation was told there were institutions for delinquents, operated under the jurisdiction of the Ministry of Education.

The actual tour of Public School #739 began in the school physician's office where there was equipment to weigh and measure the child's height, to examine his eyes, to test his respiratory volume—the usual equipment for physical examination, and a medicine cabinet. Aside from the annual physical examination, it was reported that the doctor's office was used mostly for handling day-to-day complaints of children who were sick or seeking an excuse from school.

The lunchroom was an attractive area with children serving as busboys. A second-year class had old-fashioned type desks seating two children. The pupils were engaged in spelling and grammer. Girls wore a uniform consisting of a black skirt, white blouse, and red tie, or brown dresses with white collars. Boys all wore coat, trousers, shirt and tie. A manual training area had woodworking and metal equipment. There was also a drawing class featuring the theme, "Dreams and Reality." The delegation observed some in bed; however, they were not asleep but were curious and alert and giggling under the scrutiny of the delegation. There were also playrooms for children who stayed beyond the school hour. There was a pupil club—a student dramatic society, and one of the groups was making an exhibit of the school for the 50th anniversary of the revolution. Younger children had games, blocks, coloring equipment, and space to change out of their uniforms and store their outer clothing.

The school was spotlessly clean, even in the corners; there was no dust on window ledges. Particular emphasis was placed on physical fitness, and the delegation recalled that in Vinnitsa children went to school an hour before opening so that they might exercise beforehand in the park.

When asked about health education programs for students, the school officials were at first puzzled. They had very little in the way of health literature, but they explained that posters and talks were delivered to the students on the evils of smoking and alcohol. They said the best mental health activity for children was physical activity—most of the children participated in gymnastics and sports for an hour before school began, and for an hour after school. The school also arranged for hikes and overnight trips to the White Sea and elsewhere.

The general impression of the delegation was that the health unit of Public School #739 was a well functioning facility, and that further, the importance of education was reflected in overall school operation. However, it should be pointed out that in regard to the psychiatric components of the school program, the delegation was not nearly as impressed.

LENINGRAD

Pavlovska Invalid Home for Children

The Pavlovska Invalid Home is the larger of the two facilities in the Leningrad area for the care of mentally retarded children. Operated under the jurisdiction of the Ministry of Social Welfare, the Pavlovska Home provides residential care for 750 children between the ages of 4 and 18.

The delegation was told there were also separate institutions available for the care of so-called "crib-cases"—severely defective children up to the age

A staff meeting at the Pavlovska Invalid Home for Children in Leningrad.

of four. As these facilities were located elsewhere, however, the delegation did not get to see them.

While most of the children referred to the Pavlovska Home are severely retarded, criteria for admission also include organic brain damage, epilepsy, paraplegia and quiescent cerebral palsy.

The Home itself is located on the grounds of a children's hospital. A polyclinic completes the complex and medical resources are reported readily available. Entry to the Home is through a pleasant lobby decorated with flags, a bust of Lenin and posters commemorating the 50th anniversary of the Russian revolution.

Upon admission to the Home, children are divided into groups by age, learning potential and motivation. There is an educational program at the Home of eight year's duration with an emphasis on personal hygiene, interpersonal relations and work training. The delegation particularly noted workshops for instruction in carpentry, sewing and shoe manufacture. The aim of the Home's program is to make as many of the children as self-sufficient as possible. The director indicated that by age 18 some of the children would be able to leave the Home and find successful employment. Some of these, it was pointed out, would be able to work in the workshops of the neuro-psychiatric dispensaries.

Many of the children, however, would be unable to make such progress and, of the 750 children in residence, it was reported that 100 were in need of bed care.

As with most of the installations visited by the delegation, the Pavlovska Invalid Home was well staffed. For the 750 children in residence there was a staff of six physicians, including two psychiatrists, 30 nurses, 50 teachers specially trained to work with mentally retarded children, two logopeds and 250 ward maids and auxiliaries.

Constant care is provided through a system where nurses work a 24-hour shift, after which they were off duty for four days. It was reported that the Home's complement of staff was consistently filled. Should a vacancy

Dining Hall, Pavlovska.

occur, it will be filled by existing staff working an additional full or half-shift.

The delegation observed a number of classrooms at the Home. At the first room visited a number of children were being taught the names of objects through the use of picture cards. At a workshop, older boys, about the age of 14, were folding and gluing boxes which would be used to hold toys. As in the adult workshops, the materials produced in the Home workshops were sold for a profit.

In a third classroom of some 22 boys, children were stringing beads, pasting, making bags, and studying pronunciation of words. This room also contained a television set and many toys.

A class of severely defective children was observed identifying objects on blocks. Still another class was working with clay and stacking blocks.

It was the delegation's impression that the children were well cared for. At the time of the visit the children were neatly dressed in clothes that looked as if they had just been freshly laundered, starched and ironed. Granting that the children might have been spruced up for the visit, there was general agreement that this degree of care and attention to detail could not have been accomplished overnight.

The overall impression of the delegation was that the Pavlovska Home was a high quality school and hospital facility. While the program seemed "benignly custodial" it was striking that, even for these severely impaired children, efforts were being made to prepare them for a normal, productive life.

Although the Pavlovska Home was not a facility the delegation had particularly wanted to see, it was nonetheless a worthwhile experience. Taken as an example of a facility for chronics, the delegation was at a loss to explain why we were having such difficulty in getting to visiting a facility for adult chronic patients.

APPENDICES

MINISTRY OF HEALTH OF THE USSR*

INSTRUCTIONS

for immediate hospitalization of the
mentally ill who present a danger to the public

Moscow, 1961

AFFIRMED by the Deputy Minister of Health of the USSR, I. Kochergin, October 10, 1961.

COORDINATED with the Procurator's Office of the USSR, Deputy Chief Procurator of the USSR, A. Mishutin, October 10, 1961.

COORDINATED with the Ministry of Internal Affairs of the RSFSR, Deputy Minister of Internal Affairs of the RSFSR, P. Romashkov, October 9, 1961.

In a number of cases the need for preventing dangerous acts on the part of the mentally ill requires their immediate placement in psychiatric institutions. In accordance with this need:

1. When the mentally ill person presents a clear danger to others or to himself, health agencies shall have the right to place him in a psychiatric institution without the consent of the patient himself and his relatives or guardians (in the form of rendering immediate psychiatric aid).

2. In the psychiatric institution the hospitalized patient shall, within 24 hours, be examined by a special commission composed of three physicians-psychiatrists, who will consider the question of the correctness of his placement and shall determine the need for his further stay in the institution.

The patient's nearest relatives shall be informed about his hospitalization.

3. The principal consideration for compulsory hospitalization shall be the social danger of the patient, indicated by the following characteristics of his illness:

a) psychomotor excitation together with inclination to aggressive acts;

b) incorrect conduct indicated by the presence of psychic disturbances (hallucinations, delirium, psychic automatism syndrome, disturbed consciousness syndromes, pathological impulsiveness), if such conduct is accompanied by acutely expressed affective tension and striving for realization;

c) Systematized delirium syndromes of a chronic progressive course, if they motivate the socially dangerous conduct of the patient;

d) Conditions of hypochondric delirium calling forth the patient's incorrect aggressive attitude toward individual persons, organizations and institutions.

The conditions of illness enumerated above, which contain doubtless social dangers, may be accompanied by externally correct behavior and dissimulation. In this connection extreme caution should be exercised in appraising the psychiatric condition of such persons so as to, without expanding the criteria calling for immediate hospitalization, at the same time, by timely confinement, prevent the possibility of the commission of socially dangerous acts on the part of the mentally ill person.

The enumeration of criteria calling for immediate hospitalization is not exhaustive: it is merely an enumeration of the most commonly encountered conditions of illness fraught with social dangers.

4. A condition of simple, even though grave, alcoholic intoxication shall not be considered to indicate immediate hospitalization in psychiatric hospitals; neither shall a state of intoxication caused by other narcotic substances (excepting acute intoxication psychoses and psychotic variations of states of abstinence), nor shall affective reactions of persons not suffering from mental illness.

5. Immediate hospitalization shall be effected directly by physicians-psychiatrists, and in areas where no psychiatric institutions exist by general physicians, although the patient must immediately be sent to the nearest psychiatric hospital.

6. In cases of immediate hospitalization the physician committing the patient must provide a detailed report of the medical and social factors indicating immediate hospi-

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Translation by U.S. Dept. of State, Div. of Language Services.

talization, at the end of which report he is to show his place of work, his position, his name and the date of commitment.

7. Local police organs shall, in cases of need (when objections are raised by the patient's relatives or guardians and when they offer resistance), at the request of persons mentioned in par. 5. hereof, provide assistance to medical personnel in effecting the immediate hospitalization of the mentally ill.

8. Patients hospitalized in psychiatric institutions shall be placed in the sections appropriate to their psychiatric condition for the purpose of active therapy and are subject to mandatory (no less than once a month) reexamination by a special commission composed of 3 physicians-psychiatrists for the purpose of deciding on the need of their further stay in the hospital. When the psychiatric condition of the patient improves or when the clinical picture of the illness changes in a manner which eliminates the social danger of the patient, the physicians' commission shall decide on the possibility of the patient's release. Such a patient's release is to be made into the custody of his relatives or guardians.

9. If a patient who is subject to release from the hospital in accordance with medical criteria is in a condition in which he cannot be left to himself and does not have a place of permanent residence or people close to him who would be obliged to care for him, he may be released from the hospital only by means of transfer to guardianship. When necessary the hospital shall take steps to establish guardianship over the patient.

10. The hospital shall inform the nearest relatives of the patient about his release, as well as a psychoneurological dispensary, where such patients shall be especially cared for, being given systematic prophylaxis therapy.

Responsible for publication: Chief of the Organizational and Methodological Office of the Psychiatric Hospital of the Bashkir Republic,

M. SUSLINA

Efficacy of Therapy

(to be filled out when patient is discharged)

Physician in charge of work therapy

Loose Leaf Stub No. ______

for individual registration
of completed production

for ____________ 196___.

Shop ____________ Dept. ________

Patient's name ____________

No. of days worked ____________

Types of completed work	Quantity of production

Total remuneration ____________

Physician's conclusions:

Physician in charge of work therapy

Types of work / Day of month											Production accepted (signature)
16											
17											
18											
19											
20											
21											
22											
23											
24											
25											
26											
27											
28											
29											
30											
31											
Quantity of production											
Price											
Total											
Quantity for month											
Total for month											

Foreman (Workshop instructor) ________ Accounting clerk ________ Patient (Med. nurse) ________

Chart 1

Therapeutic-industrial Workshop at Hospital im. Kashchenko ____________ 196____

Loose leaf of individual registration of completed production No.________

Patient's name ____________ Dept.________ Shop________

Type of work											Prudoction accepted (signature)
day of month											
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
Quantity of production											
Price											
Total											

Foreman (Workshop instructor) ____________ Accounting clerk ____________ Patient (Med. nurse) ____________

For case history

Loose Leaf Stub No.______

individual registration of completed production

for ____________ 196______

Shop ____________ Dept.______

Patient's name ____________

No. of days worked ____________

Types of completed work	Quantity of production

Total remuneration ____________

Physician's conclusions:

Physician in charge of work therapy:

Chart 1, continued

Psychiatric Clinical Hospital No. 1 im. P. P. Kashchenko

CASE HISTORY No. **File No.**

M	F	For therapy	For expert testimony forensic psychiatry work military	Admission to psychiatr. hosp.		Admission to this hospital		
				first	repeated	first	repeated	which time this year

Last name, first name, patronymic

Year of birth	Family status	Nationality	Education	Profession

Address

(rayon)

Place of work

Work or occupation

Address, telephone, names of relatives

Admitted 19

Discharged 19

Transferred (where)

Died 19

How many days spent in bed

State at the time of discharge

Recovery

Complete remission

Incomplete remission

Improvement in hosp.

Without change

Deterioration

Duration of illness

Duration of present episode, exacerbation

Work ability

Restored

Reduced

Lost temporarily

Lost steadily

Diagnosis	Psychiatric	Somatic
At the time of discharge	 (nosological) (form of illness)	

Treating physician:

Head of department:

Pathologo-anatomical diagnosis:

Cause of death:

Chart 2

At the time of admission

Base hospital No. ____________ Invalid state: group ____________

first page continued Deadline for re-examination ____________ 19 ______

Temporary Control Commission in department ____________

Initial base hospital from ____________ 19 ____

Issued by: ____________

Report sent to Medical Experts; Commission on Workers' Disability ____________ 19 ____

with recommendation ____________

Decision of Med Exp Comm: additional therapy to: ____________

Transferred to invalid state ____________ 19 ____

Group ____ Deadline for re-examination ____________ 19 ____

____

Report on guardianship sent on ____________ 19 ____

Guardianship from: ____________ 19 ____

Remarks on transmittal of other reports ____________

____

Remarks on issuance of base hospital			
No. of base hospital	For period:	Date of issue	Signature of physician

Antidysentery vaccination ____________

Antityphus vaccination ____________

Other ____________

Therapy of patient

Dept No.	from	to	Physician's name	from	to

Extract from case history sent to:

Psychiatric hospital ____________ of rayon ____________

Chart 2, continued

Who assigned to hospital	Who delivered to hospital

Diagnosis of physician who assigned ______________________________

____

Diagnosis at admission (physician on duty) ______________________________

____

Admitted	Documents, valuables
______________ 19 ______ ________ hours ________ minutes Data of sanitation services complete, partial, washing Temperature ______________ Weight ______________	Med nurse on duty

Psychic and somatic state of patient at admission	Assignment of physician on duty Dept. No. ________ Medical prescriptions and instructions

Chart 2, continued

Record of physician on duty (cont'd)

Medical prescriptions and instructions

Chart 2, continued

PHS registration form No. 3a
Approved by Ministry of PH, USSR
8/16/54

LOOSE LEAF FOR CASE HISTORY No.

Last name, first name and patronymic of patient ______________________________

Department ____________________ Ward No. ______________ Loose leaf No. __________

Date	Temperature	Pulse	Course of illness	Instructions (regimen, diet, medications, physiotherapy, etc.)
1	2	3	4	5

Chart 2, continued

Date	Temperature	Pulse		Instructions (regimen, diet, medications, physiotherapy, etc.)
1	2	3	4	5

Chart 2, continued

Inquiries about patient and other therapeutic establishments

Date	Sent to:

Place for gluing on responses to inquiries

Chart 2, continued

Therapy which was carried out

Chart 2, continued

Place for gluing on results of analyses, examinations

Case history contains______________pages

________________________19______ Senior med. nurse________________________

Chart 2, continued

Date of admission	Name of shop	Date of discharge

Efficacy of work therapy

Physician in charge of work therapy ____________
(signature)

Therapeutic-industrial Workshops at
Hospital im. Kashchenko

REGISTRATION CARD FOR WORK THERAPY

No. ____________

Patient ____________
(*last name, first name, patronymic*)

Department ______ Case history No. ____________

Date of admission to hospital ____________

Date of discharge ____________

Chart 3

Date of birth ______________________

Place for gluing on loose leaf stub of individual registration of completed production

Profession ______________________

Duration of illness ______________________

Diagnosis ______________________
(nosological form)

____
(syndrome)

Special remarks ______________________
(supervision)

____
(basic type of active therapy)

____
(characteristics of physical state)

____
(recommendations)

Treating physician ______________________
(signature)

Chart 3, continued

SCHEDULE OF EXAMINATION

1. Name ______________________
____
2. Birthdate ______________________
3. Address ______________________
9a. Heredity

4. Sex M–1, F–2 1. ☐
5. Age at the moment of examination[x] 2. ☐
6. How many years is ill 3. ☐
7. Out-patient Clinic ______________________ 4. ☐
8. Active–1, Archives–2, Not registered–3 5. ☐

Relatives	Total number (incl. dead)	Ill	Codes of mental disorders	Relatives	Total number (incl. dead)	Ill	Codes of mental disorders
	A	B	C		A	B	C
Father..........................	1			Maternal Uncles..............			
Paternal Grandfather	1			do Aunts................			
do Grandmother........	1			do Cousins............			
do Uncles...............				Brothers........................			
do Aunts..................				Sisters..........................			
do Cousins..............				Nephews.......................			
Mother..........................				Nieces..........................			
Maternal Grandfather.........	1			Grandsons.....................			
do Grandmother........	1			Granddaughters..............			

[x] Here and everywhere—Number of full years.

Chart 4

Chart 4, continued

9b. Patient's children: Has—1, No—0.

Age of the children[x]	Sex M—1 F—2	Born before the disease—1 Born after the disease—2	From which marriage (number)	If lives separately—from what age	Presence of mental disturbances (If schizophrenia—record the name and address)	If dead—the cause of the death[xx]
A	B	C	D			
a						
b						
c						
d						

10. Injuries of the prenatal period (heavy diseases, traumas, peurperial toxicoses)[xxx] .... 7. ☐

11. Pathologic delivery (undue time, asphyxia, birth traumas, etc.)[xxx] .... 8. ☐

12. Particularities of the patient development:

a) Enuresis, somnabulism, convalses, cloudness of consciousness and rudimentary psychotic disorders in exogenic factors[xxx] .... 9. ☐

b) Neurotic reactions (nightmares, episodes of obsessions and phobias, psychic anorexia, etc.) .... 10. ☐

c) Retardation of motor development .... 11. ☐

d) Precocious development .... 12. ☐

[x] For dead—year of the death.

[xx] Suicides—1; accident, connected with a mental disease—2; without association with a mental disease—3; a somatic illness—4.

[xxx] For Items 10–12: Absent—0, Unmarked—1, Marked—2, Not known—99.

13. Signs of oligophrenia: Absent – 0, Feeblemindedness – 1, Imbecility – 2 .... 13. ☐
14. Upbringing: In the family – 1, In Children's Home – 2, At relatives – 3, In another family – 4, Not known – 99 .... 14. ☐
15. Education: Illiterate – 1, Primary school or seven-grade school – 2, Attended Secondary school – 3, Completed Secondary school – 4, Secondary specialized school – 5, Attended Higher Educational Establishment – 6, Completed Higher Educational Establishment – 7 .... 15. ☐
16. Premorbid personality and conditions of life before the onset of the disease.[x]

Description of the character	Premorbid personality	Code of the premorbid personality	Level of Social adaptation	Qualification	Invalidity	Exogenic noxious factors	Notes
		A	B	C	D	E	

[x] Codes – See Instructions.

17. Course of Illness

Brief description of the disorder		Qualification of the syndrome	Time of existence of the syndrome	Age at the period of the syndrome	Years, Quarters
positive	negative				
					1
					2
					3
					4
					1
					2
					3
					4
					1
					2
					3
					4
					1
					2
					3
					4

Chart 4, continued

Characteristics of the course	Code of the syndrome	Therapy		Level of social adaptation	Qualification	Invalidity	Exogenic noxious factors		Dangerous actions	Number of attempts to commit suicide	Hospitalization			Notes
		kind	effectivity				Character	Time of action			Number in recent year	Predominant cause	Number of	
A	B	C	D	E	F	J	H	I	K			L		

Chart 4, continued

18. Forms of schizophrenia:

Simple progressive—1, simple sluggish (psychopathic-like, pseudo-neurotic)—2, malignant (hebephrenic and lucide-catatonic)—3, sluggish paranoid—4, paranoid—5, periodic—6, shift-like—7, other—8........ 16. ☐

19. Number of attacks (shifts) in periodic or shift-like schizophrenia........ 17. ☐

20. How many years had passed since the onset of the disease when the patient consulted a psychiatrist for the first time? (If in the same year—rate 00)........ 18. ☐

21. How many years had passed since the onset of the disease when the diagnosis "schizophrenia" was made? (If in the same year—rate 00)........ 19. ☐

22. Life conditions of the patient (at the moment of examination):

Family status (lives alone /unmarried/—1, lives alone /divorced, widowed/—2, lives with the parents or other relatives—3, lives with his wife, children—4, lives with relatives but has own household—5 .... 20. ☐

Patient's income .... 21. ☐

Income per a member of the patient's family (1, 2, 3, 4)........ 22. ☐

Housing conditions (satisfactory—1, unsatisfactory—2)........ 23. ☐

Chart 4, continued

23. Needs the following kind of medical and social aid:

AID	Actually gets (Yes – 1, No – 0)	Needs (Yes – 1, No – 0)
Observation in the Out-patient Clinic		
Drug treatment in the Out-patient Clinic		
Maintenance therapy in the Out-patient Clinic		
Hospitalization to a psychiatric facility		
Admission to the Day Care center		
Admission to the Invalid Home for patients with chronic diseases		
Psychoneurotic sanatorium		
Occupational Workshops		
Compulsory treatment		
Employment		
Patronage		
Invalidization		
Improvement of living conditions		
Does not need		
Other (specify)		

24. Particularities of the case, additional notes (on History of Illness and records in the Schedule)

Date of examination____________________Name of Examiner____________________

Chart 4, continued

MINISTRY OF HEALTH OF THE USSR*

INSTRUCTIONS

for carrying out medico-legal psychiatric
examinations in the USSR

Moscow, 1955

AFFIRMED by the Minister of Health of the USSR, M. Kovrigina, May 31, 1954.

COORDINATED with the Ministry of Justice of the USSR; with the Ministry of Internal Affairs of the USSR; with the Procurator's Office of the USSR.

Chapter I

General Provisions

Note: The Instructions for carrying out medico-legal psychiatric examinations in the USSR dated Feb. 17, 1940, affirmed by the Ministry of Health of the USSR, the Ministry of Justice of the USSR, the Ministry of Internal Affairs of the USSR, and the General Procurator's Office of the USSR, are to be considered as abrogated upon publication of the present Instructions.

1. The principal goals of medico-legal psychiatric examination are the following:

a) determination of the psychiatric condition and conclusions as to the mental competence of persons who have been detained or brought to account on criminal charges, concerning whom the investigating agencies and the court have doubts as to their mental health, and also determination of their psychiatric condition during the period of inquiry and conclusions on necessary medical measures with respect to persons judged incompetent or those who became mentally ill after the commission of a crime;

b) determination of the psychiatric condition of persons showing signs of psychiatric disturbance during the period of their punishment, and the rendering of conclusions on necessary medical measures with respect to such persons;

c) when necessary, determination of the psychiatric condition of victims and witnesses;

d) conclusions on the ability to function of persons raising the court's doubts as to their mental health, in civil cases.

2. Medico-legal psychiatric examinations are to be conducted by the health agencies.

Operative direction of medico-legal psychiatric examinations shall be carried out by the Ministries of Health of the Union and Autonomous Republics, by Kray, Oblast and City Health Departments through Republic, Kray, Oblast and City psychiatrists.

Methodological and scientific direction of medico-legal psychiatric examinations shall be effected by the Ministry of Health of the USSR through the Professor Serbsky Scientific Research Institute of Medico-Legal Psychiatry.

3. In conducting medico-legal psychiatric examinations the psychiatric institutions (hospitals, dispensaries and polyclinics) as well as individual physicians shall be guided by the appropriate Articles of the Criminal Code and the Criminal Code of Procedure, as well as by the appropriate instructions and orders issued by the Ministry of Health of the USSR.

4. Medico-legal psychiatric examinations shall be carried out at the request of the investigative agencies, upon court determination, and with respect to convicted persons at the direction of the administrations of places of deprivation of freedom.

Note: During the medico-legal psychiatric examination of persons for whom such examination has been requested, representatives of the agency conducting the investigation and representatives of the Procurator's Office may be present.

5. Medico-legal psychiatric examinations may be conducted in an institution, or with the person examined in an ambulatory state, in court and in the investigator's office, and, in exceptional cases, in the absence of the person being examined, in absentia, based on the evidence in his case.

6. Medico-legal psychiatric conclusions on the state of mental health, on the com-

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**U.S. Department of State translation.*

petence and ability to function of the person being examined, shall be based on the psychiatric examination and on a study of the evidence in the criminal case, as well as on information about his past life, documents and data on former illnesses.

7. All medical institutions (hospitals, clinics, dispensaries, polyclinics and others) are obliged to provide information and data concerning the person being examined (history of illnesses, medical data, analyses, etc.) for the purpose of medico-legal psychiatric examination.

8. The medico-legal psychiatric conclusions are to be stated in the form of a report. The report of a medico-legal psychiatric examination shall consist of the following parts:

a) an introduction indicating the place and time of the examination; the composition of the commission of experts; the last name, first name, patronym and age of the person being examined and a brief description of the criminal case against him citing the Article of the Criminal Code involved; by whom the examination was requested and for what reason;

b) information on that person's former life, from whom such information has been received, information on his former illnesses together with a reference to the documents confirming such data, and the history of his present illness;

c) a detailed description of the physical, neurological and psychiatric condition of the person being examined during the period of the examination and data of special laboratory investigations;

d) the concluding part of the statement containing an evaluation of the psychiatric condition of the person being examined during the period of the examination and a diagnosis of his mental illness, if such diagnosis can be made; with respect to persons criminally charged (the accused)—an evaluation of the mental condition of the person being examined at the moment of the commission of his crime and a conclusion as to his competence connected therewith; with respect to persons already convicted—a conclusion on their ability to serve their sentence in places of deprivation of freedom; with respect to plaintiffs and respondents in civil cases—on their ability to function; with respect to witnesses and victims—on their ability to testify; with respect to persons who have been indicted and with respect to persons under confinement who have been adjudged to be mentally ill and incompetent—on the necessary medical measures. The concluding part of the statement must also furnish answers to other questions asked by the court and investigative agencies.

9. The statement of a medico-legal psychiatric examination shall be signed by all the members of the commission, who shall bear equal responsibility for its contents. In the event that one of the experts does not agree with the conclusions of the commission, he may refuse to sign the statement and present a dissenting opinion which is to be annexed to the statement of the examination.

10. In the event that the conclusions of the examination are insufficiently clear or incomplete, and also in the event of differences of opinion between the experts, the investigative agencies or courts shall propose to the health agencies to repeat the examination. The health agencies shall organize a new commission of experts through the Republic, Kray, Oblast or City psychiatrist, inviting the most qualified psychiatrists to participate in the work of the commission, or the agences may send the persons to be examined to special medico-legal psychiatric institutions, to medico-legal psychiatric departments of psycho-neurological hospitals, and in particularly complex cases to the Professor Serbsky Central Scientific Research Institute of Medico-Legal Psychiatry of the Ministry of Health of the USSR.

11. All dossiers, medical histories, copies of statements, reports and correspondence on medico-legal psychiatric examination questions are to be gathered in a separate file.

Chapter II

Rights and obligations of medico-legal psychiatric experts

12. Only persons who are doctors of medicine and specialized in psychiatry may become medico-legal psychiatric experts.

13. Physicians-psychiatrists who conduct medico-legal psychiatric examinations are subject to the provisions on the rights and obligations of experts contained in the Criminal Code of Procedure.

14. A medico-legal psychiatric expert shall have the right, with the permission of the investigating agencies, to acquaint himself with those circumstances of a case which he will need for the purpose of conducting an examination. During the process of a court investigation the expert shall have the right to ask questions of victims, the accused and witnesses.

In those cases when the materials presented to him are inadequate for reaching a conclusion, he shall state his inability to come to a conclusion and shall indicate precisely what materials or documents, what additional investigation and inquiries are needed and what additional questioning of other persons, (the accused, the victims and witnesses) he needs for the purpose of conducting his examination.

In the event that the expert does not receive the information he requested he shall draw up a statement in which he explains in detail his motives for refusing to reach a conclusion.

15. In those cases when the medico-legal psychiatric expert is unable to reply to questions asked of him during the examination, he is obliged to provide a motivated explanation.

16. The medico-legal psychiatric expert does not have the right to publicize the investigative materials of a case which have become known to him, nor the data obtained during the medico-legal examination and he must communicate these only to the investigative and court agencies at their request.

For publicizing investigative materials and examination data the expert shall bear responsibility in accordance with the appropriate Articles of the Criminal Code.

17. The medico-legal psychiatric experts shall keep a record of the examinations they conduct in the established form and shall send it to the appropriate health agencies (Republic, Kray, Oblast or City psychiatrist).

Chapter III

Ambulatory examination

18. Ambulatory examinations are to be conducted by the permanent medico-legal psychiatric ambulatory commissions organized by local health agencies.

19. Ambulatory commissions are to be organized to work in local psycho-neurological hospitals or in one of the local medical institutions (dispensary, polyclinic, etc.).

20. Ambulatory medico-legal psychiatric examinations shall be conducted by a commission composed of three physicians-psychiatrists, one to serve as chairman and two as members of the commission, one of the latter being designated as reporter. The personal composition of the commission is to be determined by the local health department upon the recommendation of the Republic, Kray, Oblast or City psychiatrist.

Note: In those locations where a commission of three psychiatrists cannot be established a commission composed of two physicians-psychiatrists shall be acceptable and in exceptional cases an ambulatory examination may be conducted by one physician-psychiatrist.

21. With reference to persons being examined by an ambulatory commission of experts an ambulatory history of the illness shall be established and the data forming the basis of the conclusion shall be entered into this record; a statement of the examination is also to be composed.

22. In the event the members of the commission encounter difficulties in arriving at a conclusion as to the mental health, the competence or ability to function of the person being examined, the ambulatory commission shall provide a conclusion indicating the need for the conduct of an institutional inquiry.

Chapter IV

Institutional Examination

23. Institutional medico-legal psychiatric examinations are to be conducted in psychiatric institutes, clinics and psycho-neurological hospitals.

24. Persons to be examined shall be placed in special medico-legal psychiatric sections of psycho-neurological hospitals; in the absence of such special sections they shall be placed in specially assigned, if possible isolated rooms of the hospitals' general sections.

25. Institutional commissions of experts shall be set up in institutions where institutional inquiries (par. 23) are to be conducted. In psychiatric clinics and psycho-neurological hospitals experts' commissions shall be organized to comprise no fewer than three persons:

a) a chairman—the Chief Physician or Administrator of the medical part of the hospital (clinic);

b) a permanent member of the commission—the chief of the medico-legal psychiatric section or other physician of the hospital (clinic), to be selected from among those who have received special medico-legal psychiatric training;

c) a physician-reporter, who keeps the person to be examined under constant observation.

In psychiatric institutes commissions of experts shall be formed on the basis of the statutes pertaining to the institutes.

26. The time of an institutional inquiry shall not exceed thirty days.

In the event that it should not be possible to reach a final conclusion on the mental health and competence of the person being examined within the limits of this time period, the institutional commission of experts shall issue a motivated decision on the need to extend the time of the inquiry, sending a copy of this decision to the agency which had requested medico-legal psychiatric examination.

Chapter V

Examinations in court, at the investigator's office and in places of deprivation of freedom

27. In court, at the investigator's office and in places of deprivation of freedom medico-legal psychiatric examinations may be conducted by a single physician-psychiatrist or by a commission composed of several physician-psychiatrists, invited by the court, the investigator or the administrator of places of deprivation of freedom.

28. In the event that at such examination in the investigator's office, in court and in places of deprivation of freedom difficulties arise in arriving at a conclusion on the mental health and competence of the person being examined, the expert physician may reach the conclusion that the examination be conducted by a commission or that the person being examined be sent away for institutional examination.

29. Physicians conducting medico-legal psychiatric examinations in the investigator's office, in court and in places of deprivation of freedom are accountable for their work to the appropriate health agencies.

Printing office of the Ministry of Justice of the USSR

RSFSR SUPREME COURT CASE

A court may find that the crime was committed in a state of sudden strong mental agitation solely in the case when such agitation was provoked by unlawful actions of the victim.

(Extract)[1]

By a sentence of the People's Court of the City of Cherkessk [a certain] Gordienko was sentenced in accordance with Article 104 of the Criminal Code of the RSFSR.[2]

The Criminal Board of the Regional Court of the Karachaevo-Cherkessk Autonomous Region [in Northern Caucasia] affirmed the [above mentioned] sentence without any modification.

The Deputy of the Procurator General of the RSFSR lodged a protest with the Criminal Board of the Supreme Court of the RSFSR against the sentence [of the court of first instance] and the decision of the Appeals Court with a motion to remand the case and retry same in accordance with Article 103 of the Criminal Code.[3]

Having reviewed the case, the Criminal Board of the Supreme Court of the RSFSR complied with the protest.

The investigating organs charged Gordienko with the intentional homicide of [a certain] Aliev during a mutual quarrel and a scuffle which arose therefrom, according to Article 103 of the Criminal Code of the RSFSR.

The court, however, found Gordienko guilty of the intentional homicide of Aliev, committed in a state of sudden strong mental agitation provoked by violence on the part of the victim.

On November 8, 1966 Gordienko came to his acquaintance Kalinin living in the city of Cherkessk, and together with him and other companions indulged throughout the evening in alcoholic beverages. In the evening, Aliev came to Kalinin, and he also participated in drinking alcoholic beverages. Aliev and Gordienko had known each other and maintained a normal relationship. Due to their state of intoxication, [however] a quarrel arose between Gordienko and Aliev. Insulting each other they grabbed one another's clothes, and falling down from the bed on which they were sitting, started a scuffle. Aliev took a bottle and hit Gordienko over the head with it. Rising on his knees and having been told by Kalinin that his head was bleeding, Gordienko picked up a knife from the trunk and stabbed Aliev who was lying on the bed in the chest and abdomen causing mortal injuries.

The circumstances of the case bear out that the violation in question was not committed in a state of sudden strong mental agitation.

Being in a state of strong intoxication Gordienko and Aliev started quarreling for an insignificant reason, i.e. the sweater Aliev was wearing. For this reason they started insulting each other and fighting.

Thus, the cause of their quarrel and consequent fighting was not violence or grave insult on the part of the victim, but a state of intoxication of both the convicted person and the victim.

During the court trial Gordienko admitted that he was in a state of strong intoxication, and therefore did not remember from where he got the knife and how he stabbed Aliev with it.

At the new trial the court shall examine the correctness of the charge brought by the organs of the preliminary investigation against Gordienko according to Article 103 of the Criminal Code of the RSFSR and, in accordance with the evidence obtained, pass the proper sentence.

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[1] *Biulleten' Verkhovnogo Suda RSFSR* [Bulletin of the Supreme Court of the RSFSR], No. 9/1967. p. 6.

[2] It reads as follows:

> Article 104. *Intentional homicide committed in state of strong mental agitation.* Intentional homicide committed in a state of sudden strong mental agitation provoked by force or grave insult on the part of the victim, or provoked by any other unlawful actions of the victim, if these actions have resulted or could result in grave consequences for the guilty person or his near ones, shall be punished by deprivation of freedom for a term not exceeding five years or by correctional tasks for a term not exceeding one year.

[3] It reads as follows:

> Article 103. *Intentional homicide.* Intentional homicide committed without the aggravating circumstances indicated in Article 102 of the present Code shall be punished by deprivation of freedom for a term of three to ten years.

Considering the above stated case the Criminal Board of the Supreme Court of the RSFSR vacated, by its Resolution of April 25, 1967, the sentence of the People's Court as well as the decision of the [Appellate] Board of the Regional Court with regard to Gordienko and referred the case for a new [court] trial.[4]

TABLE OF CONTENTS OF COURT PSYCHIATRY*

Approved by the Ministry of Higher and Specialized Secondary Education as a textbook for law institutes and law schools

Published by: Publishing House "Yuridicheskaya Literatura," Moscow, 1967

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[4] The following statutory provisions are pertinent in the above case:

Art. 12 of the Criminal Code of the RSFSR: "A person who commits a crime in a state of intoxication shall not be freed from criminal responsibility."

Art. 62 of the Criminal Code dealing with the application of compulsory measures of a medical character to alcoholics and drug addicts.

Art. 403–413 of the Code of Criminal Procedure of the RSFSR on proceedings for the application of compulsory measures of a medical character. The above-cited provisions may be located [in English translation] in the book *Soviet Criminal Law and Procedure;* the RSFSR Codes, with an introduction and analysis by H. J. Berman, Cambridge, Mass., Harvard University Press, 1966, except for a recent supplementary amendment, to wit a RSFSR Decree of April 8, 1967 on compulsory [medical] treatment and labor re-education of malicious drunkards (alcoholics) promulgated in RSFSR *Vedomosti*, 1967, No. 15, item 333, confirmed as law April 12, 1967 in RSFSR *Vedomosti*, 1967, No. 16. item 382.

Translated and footnotes supplied by Dr. Zenon Nizankowski, European Law Division, Law Library, Library of Congress, January 1968.

**U.S. Department of State trnslation.*

Chapter 12. Manic-depressive psychosis.
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ANNEXES

Annex 1. Instructions for carrying out medico-legal psychiatric examinations in the USSR, dated May 31, 1954.
Annex 2. Circular letter.
Instructions for carrying out medico-legal psychiatric examinations in civil cases, dated September 4, 1965.
Annex 3. Instructions on the procedure of using forcible therapy and other medical measures with respect to mentally ill persons who have committed socially dangerous acts, dated February 14, 1967.
Dictionary of terms most frequently used in psychiatry.

FOOTNOTES TO PART II

[1] H. Berman. *Justice in the USSR.* Revised ed. 1963. 315 pp.

[2] A. Buneev. Forensic psychiatry. *Bol'shaya Meditsinskaya Entisiklopediya,* 2d ed., Vol. 27, 1962, pp. 207–219. Translated by Aronson and Field.

[3] Berman, *op. cit.*, p. 319.

[4] Foreign Languages Publishing House. *Fundamentals of Soviet Criminal Legislation, the Judicial System, and Criminal Court Procedure,* Vol. 6, 1960.

[5] *Ibid.*, Vol. 8.

[6] *Ibid.*

[7] *Ibid.*

[8] *Ibid.*, Vol. 9.

[9] For the only reference to reported cases involving the Soviet standard for responsibility, see Berman, *op. cit.*, pp. 320–321.

[10] The material described in this section is from two sources, first, the Ministry of Health, *Instructions for Carrying Out Medico-Legal Psychiatric Examination in the U.S.S.R.*, 1955, and second, on conversations with psychiatrists at the Serbskii Institute of Forensic Psychiatry. The instructions are reprinted in the Appendix.

[11] Babaian. Forensic psychiatry in the USSR. In: *Some Problems of Psychiatric Service Organization and Forensic Psychiatric Examination in the U.S.S.R.*, Vol. 52, 1962.

[12] Ministry of Health, *op. cit.*, instruction 16.

[13] Cf. *United States* v. *Sharp,* 381 F. 2d 708, 4th Cir. 1967.

[14] See generally *Soviet Criminal Law and Procedure: The RSFSR Codes,* Introduction and analysis by H. Berman, 1966. In particular see Criminal Code Articles 58–63, pp. 175–178 on compulsory measures of a medical character applied to the mentally ill, and Code on Criminal Procedure Articles 403–413, pp. 418–424 on proceedings for the application of compulsory measures of a medical character.

[15] See S. Semenov, The problem of limited responsibility, *Zhurnal Nevropatologii I Psikhiatrii Im. Ss. Korsakova,* 66: 1268–1272; but cf. Conrad, *Crime and Its Correction* 1965, pp. 155–517, as he suggests that only those found responsible who later become ill are given treatment.

[16] Babaian, Legal rights of mental patients in the USSR. This article was given to the delegation by Dr. Babaian, with no reference on whether or not it was published.

[17] *Ibid.*

[18] D. R. Lunts, The legal-psychiatric significance of mental anomalies not excluding responsibility. *Zhurnal Neuro-Patologii I Psikhiatrii Im. Ss. Korsakova,* 67: 605–608, 1967. English translation by Z. D. Knowles, 1968.

[19] Semenov, *op. cit.*

[20] Lunts, *op. cit.*

[21] This figure was given to the delegation by Dr. Babaian, Deputy Director, Central Department of Preventive and Curative Services; President of the Psychiatric Council of the Ministry; and President of the Committee on Narcotics.

[22] Babaian, see footnote 16.

[23] These procedures are set out in Ministry of Health, *Instructions for Immediate Hospitalization of the Mentally Ill Who Present a Danger to the Public*, 1961. These instructions are reprinted in the Appendix.

[24] Babaian, see footnote 16.

[25] Ministry of Health, see footnote 23, instruction 8.

[26] Field. Approaches to mental illness in Soviet society: Some comparisons and conjectures. *Social Problems*, 7(4): 277, 283, 1960.

[27] Babaian. The organization of psychiatric services in the USSR. *Int. Journal of Psychiatry*, 1, 31, 1965. In general, work therapy is an integral part of the Soviet approach to treating mental illness. Workshops are set up in every psycho-neurological clinic and the patients are put to work in them as part of their treatment. See Melekhov, Social Assistant to Mental Patients and the Problems of Assessment of Capacity for Work. Paper delivered at a World Health Organization interregional seminar on mental hygiene and the organization of psychiatric services, Moscow, 1967.

[28] See Serebriakova, Psychiatric guardianship in the USSR. In: See footnote 11.

[29] Babaian, see footnote 16.

[30] *Ibid.*

[31] This information was obtained by the delegation in talks with psychiatrists at the Serbskii Institute.

[32] Babaian, see footnote 16.

[33] The delegation was interested in seeing what role lawyers played in the Soviet mental health scheme. This is one of the least publicized areas in the Soviet setup, and except for a brief mention in Babaian, see footnote 11, the delegation would not have been aware of the important role lawyers played before the delegation left for Russia.

[34] *Court Psychiatry*. Moscow: Yuridicheskaya Literatura, 1967. The translated table of contents is reproduced in the Appendix. This book was given to the delegation by Dr. G. V. Morozov and is the most recent text for Soviet lawyers. It should be a major resource in the comparative study of law and mental illness.

[35] Katz, Goldstein, and Dershowitz. *Psychoanalysis, Psychiatry and Law*. 1967.

[36] *Law in Eastern Europe*, Vol. 11. The Civil Code and the Code of Civil Procedure of the RSFSR, 1964, 17, 1966.

[37] *Ibid.*, pp. 225–227.

[38] *Foreign Family Law*. Russian Family Code, 27, 1965.

[39] *Law in Eastern Europe*, *op. cit.*, p. 227, Section 262, Judgment of the court on the claim:

> The judgment of a court whereby a citizen is declared to have limited civil capacity or to lack civil capacity is a basis for the appointment by the organ of guardianship and curatorship of a curator for the citizen of restricted civil capacity and a guardian for the citizen lacking civil capacity.

[40] The following procedures are set out in *Foreign Family Law*, *op. cit.*, pp. 19–26.

[41] Melekhov. The medical labor examination and the organization of work. *Bol'shaya Meditsinskaya Entsiklopediya*. 2d ed., Vol. 27, 1962, pp. 203–207. Translated by Aronson and Field.

[42] *Ibid.*

[43] *Ibid.*

[44] *Ibid.*

[45] Berman, *op. cit.*, p. 319.

[46] *Ibid.*, p. 322.

[47] Lunts, *op. cit.*

[48] *Ibid.*

[49] Berman, *op. cit.*, pp. 328–329.

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